



Educational Counselling during Rehabilitation: A practice report

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Project Consortium



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Introduction

Elisabeth Frankus

Lifelong learning is the key to personal development but also to economic success.¹ In times of economic crisis, high speed technological development, demanding times in one's professional life and other circumstances that can cause instability in a persons (vocational) life, one's chances in the labour market can be improved with the help of further education.

This publication aims at promoting lifelong learning opportunities for a specific target group with specific needs: patients who (after an accident or illness) have to spend several weeks or months in medical rehabilitation. These persons are often forced not only to reorganise their private life but also their professional future. In times of uncertainty, worry and physical and/or psychological restriction, a helping and accompanying hand can bring back moments of stabilisation. In most cases, patients' relatives and close friends are already exhausted by the new and often onerous conditions. In these times of change, support from professional counsellors and trainers can be profitable for patients. Integrating this service into a setting where they spend most of their time during the phase of rehabilitation – the rehabilitation centre – might reduce the gap between medical treatment and vocational comeback. This corresponds with the EduCoRe approach:

In local cooperative ventures between educational providers and local medical rehabilitation centres, the EduCoRe partnership developed, tested and evaluated a blended counselling and training offer in Austria, Germany, Italy, Denmark and Slovenia. The overall aim of this service was to support rehabilitating patients on their way back to the labour market. Besides diverse application strategies, the counselling and training deals with specific soft skills such as communication, team work, conflict management, self presentation, etc. As the five modules of the counselling and training course are

modular, the blended learning content can be adapted to the individual patient's needs.

This publication has been produced based on the experience gained during the EduCoRe project and was written by a team of educators, e-Learning facilitators and project managers from the six partner institutions in the five countries involved. This diversity reflects the different approaches and perspectives of the European partners.

The authors are well aware that the publication is not a comprehensive guide book on how to provide blended counselling and training in medical rehabilitation centres. This would need many more projects and initiatives of this kind. But this printed work can be seen as a description of experiences and insights gained in the EduCoRe project while planning, organising and delivering the counselling and training programme for patients in European rehabilitation centres. It aims at serving as a source of inspiration for similar and perhaps more elaborate educational activities of this type.

Accordingly, the publication was produced for four main groups:

- Trainers, programme developers and managers of adult education
- Staff in career and educational counselling
- Rehabilitation centres, authorities, social security/insurance organisations and other bodies in the health sector which finance and maintain rehabilitation centres
- Education and e-Learning researchers

Not all chapters might be of the same interest for all target groups. Nevertheless the described experiences, tools and recommendations may be useful at different stages for implementing blended counselling and training in medical rehabilitation centres.

The first chapter of the present publication contains general information about lifelong learning in rehabilitation centres. Medical rehabilitation centres as new places of learning are described as well as general information about the EduCoRe project and its consortium. Furthermore blended learning is thematic in its approach.

¹ Lifelong Learning Programme, Creativity and Innovation, European success stories: http://ec.europa.eu/dgs/education_culture/publ/pdf/ll-learning/creativity_en.pdf

The second chapter deals with the topic “Life in rehabilitation centres”. Here an introduction about rehabilitation and rehabilitation processes are given as well as a description of the rehabilitation staff’s role. Patients as adult learners and the topic “Prerequisites for the integration of training and counselling modules in rehabilitation centres” are also in this chapter.

Chapter three gives a brief description of the counsellor’s and trainer’s role in regard to the EduCoRe context. This part closes with the presentation of an exemplary five step model for counselling.

The fourth chapter of this publication contains the description of the EduCoRe pilot courses, which took place in Austria, Italy, Germany

and Slovenia as well as the achievements and challenges faced in this period. This part closes with an excursus about vocational counselling and training for rehabilitation patients in Denmark as a role model for vocational counselling and training in European rehabilitation centres.

The fifth and at the same time last chapter of this brochure deals with evaluation aspects and other outcomes of the pilot projects. This part points out several critical aspects and gives recommendations for interested parties such as educational providers who want to implement such a (or similar) counselling and training offer in medical rehabilitation centres.

1. Lifelong learning in rehabilitation centres

Elisabeth Frankus, Sabine Wiemann

1.1 Medical rehabilitation centres: new places of lifelong learning

1.1.1 What is lifelong learning?

Making lifelong learning a reality and promoting creativity and innovation are two of the major priorities proposed by the European Commission in its strategic vision for education and training until 2020.

Building competences and skills through high quality education and training systems is an essential part of Europe’s strategy to meet challenges such as globalisation, technical progress and the ageing of society. Knowledge, skills and competences are essential assets for individuals to succeed in the labour market and for enterprises to boost their competitiveness and innovative capacity.²

Lifelong learning is the key not only to personal development but also to economic success. This means that with the help of lifelong learning one’s chances in the labour market can be improved. The Lifelong Learning Programme (LLP) plays an important role in helping participants acquire skills and competences. Pupils, students, adult learners, teaching staff, trainers and trainees have great potential as drivers of creativity and innovation.³

High quality pre-primary, primary, secondary, higher and vocational education and training are fundamental for Europe’s success. Lifelong learning must become a reality across Europe. It is essential for growth and jobs, as well as to allow everyone the chance to participate fully in society. While national governments are responsible for education and training, some challenges are common to all Member States: Ageing societies, skills deficit in the workforce and global competition need joint responses and cooperation, with countries learning from each other.⁴ By taking part in transnational activity, people from different European countries share different views and methods in learning, teaching and training.

² Lifelong Learning Programme, Creativity and Innovation, European success stories: http://ec.europa.eu/dgs/education_culture/publ/pdf/ll-learning/creativity_en.pdf

³ Lifelong Learning Programme, Creativity and Innovation, European success stories: http://ec.europa.eu/dgs/education_culture/publ/pdf/ll-learning/creativity_en.pdf

⁴ http://ec.europa.eu/education/lifelong-learning-policy/doc28_en.htm

Access to education for adults (in the sense of lifelong learning) has to be simplified and educational offers must start from the social and educational needs of the learners and must be applied with flexible, learner-centred methodologies. Adult learning (as a vital component for lifelong learning) is essential for competitiveness and employability, social inclusion, active citizenship and personal development across Europe. However, greater efforts are needed to ensure even more adults participate in learning activities throughout their lives.⁵ This means learning opportunities have to be offered in different situations in life. Hospitals and other healthcare institutions are such new places of learning which need to be explored by adult educators.

Patients who had an accident or illness often spend several weeks or months in medical rehabilitation centres receiving long-term treatment. The treatment aims at removing or at last minimising their physical impairments and thus allowing them to re-enter the labour market and normal life. The time spent in rehabilitation centres can be used for all kinds of learning purposes. The only way to give those persons access to education during medical rehabilitation is to offer them learning options where they are: directly in the medical rehabilitation centre so they can make use of the time between treatments and therapy sessions.

Healthcare institutions as places for learning activities

Fig.1. Healthcare institutions as places for learning activities

A former Grundtvig project named eHospital (www.ehospital-project.net) investigated the potential for hospitals as places of informal learning for patients. During the project's piloting phase in which seven pilot e-Learning courses for divers target groups were developed and tested in six countries, a clear need was identified in many talks with patients and hospital staff and other stakeholders in the health system: Patients who are forced to go to medical rehabilitation

centres after hospital need support in making the right career and education choices.

This approach goes hand and in hand with the idea of the European Commission of adult learning, which stresses the relevance of adult learning to employability and mobility across the EU and at the same time the need for greater recognition in terms of visibility, policy prioritisation and resources. To avoid shortcomings, the European Commission adopted a *Communication on Adult Learning* in October 2006, followed up by an Action Plan in September 2007 containing five priority actions:⁶

1.1.2 European strategy and co-operation in education and training: The five priority actions

- To reduce labour shortages due to demographic changes by raising skill levels in the workforce generally and by upgrading low-skilled workers (80 million in 2006)
- To address the persistently high number of early school leavers (nearly 7 million in 2006), by offering a second chance to those who enter adulthood without any qualifications
- To reduce poverty and social exclusion among marginalised groups. Adult learning can both improve people's skills and help them towards active citizenship and personal autonomy
- To increase the integration of migrants in society and labour markets. Adult learning offers tailor-made courses, including language learning, to contribute to this integration process. Adult learning can help migrants secure validation and recognition for their qualifications
- To increase participation in lifelong learning and particularly to address the fact that participation decreases after the age of 34. At a time when the average working age is rising across Europe, there needs to be a parallel increase in adult learning by older workers

EduCoRe – Educational Counselling during Rehabilitation – aims at those demands while providing e-counselling and e-Learning in com-

⁵ http://ec.europa.eu/education/lifelong-learning-policy/doc28_en.htm

⁶ http://ec.europa.eu/education/lifelong-learning-policy/doc28_en.htm

bination with face-to-face sessions for patients of medical rehabilitation centres. This offer, conducted by professional counsellors and trainers tends to reintegrate these patients in the labour market.

Counsellors and trainers who work with patients of medical rehabilitation centres have to detect the proper moment to start this work, otherwise there exists a chance that the patient interrupts the learning process. Therefore it is important that the patient really wants to make use of the counselling and training offer during his/her rehabilitation phase. As the focus is set on the vocational reintegration, the patient needs to feel the desire to return to working life. If this is not the case, another aim has to be identified and to be proved that it fits in with the EduCoRe service.

The following chapter describes the EduCoRe project, its idea and phases and presents the project consortium:

1.2 The EduCoRe project

EduCoRe is a transnational cooperative project which has been funded with support from the European Commission. The project was implemented from 2008–2010 by a consortium of six partners from Austria, Germany, Denmark, Italy and Slovenia. Each project partner cooperated with one rehabilitation centre in their country.

1.2.1 The EduCoRe project's idea

EduCoRe builds on the experience gathered in the Grundtvig project eHospital (www.ehospital-project.net). This project investigated the potential of hospitals as places of informal learning and of information and communication technologies for patient education. Seven pilot e-Learning courses for diverse target groups were developed and tested in six countries. During these courses, a target group with specific educational needs was detected, and their educational needs were discussed with stakeholders in the health system:

Patients who have physical deficiencies after an accident or illness threaten their own employability and participation within society.

Fig. 2. Patients of medical rehabilitation centres

After leaving hospital, these patients spend several weeks or months in medical rehabilitation centres receiving long-term treatment which aims at removing (or at least minimising) their physical impairments and thus allowing them to re-enter the labour market and normal life.

But rehabilitation has not only a medical aspect: In many cases these patients need to undergo considerable re-orientation with regard to their career or (further) education. Many rehabilitation patients are forced to change occupation and/or need to identify the appropriate lifelong learning offers which allow them to change their career. Others, particularly older patients who make up a large proportion of rehabilitation patients, take the time-off from their ordinary lives as an opportunity to think about new learning activities which would be beneficial for their personal development.

These needs pose a challenge to the concept of lifelong counselling and lifelong learning policies. People in rehabilitation centres need tailor-made educational and career counselling, along with strengthening personal skills which enable them to cope with their precarious life situation. The idea of the EduCoRe project was that these final benefits could be reached simply through the persons that care for them in the rehabilitation centre: the staff.

Therefore the main target groups of the EduCoRe project were staff members of rehabilitation centres that want (additional to their medical and/or psychological work) to support their patients in the vocational reintegration process. The target group consisted of medical staff (doctors, nurses or physiotherapists) as well as therapeutically staff (social workers and psycho therapists).

This initial project idea had to be redefined during the project development: While testing the material in the piloting phase, it turned out that this aim was not feasible: to counsel and/or train persons – independently if the clients/patients are not healthy persons – requires specific counselling and training skills. It would be unprofessional if persons without the adequate educational background would work with persons in the context of counselling and training. Although medical rehabilitation staff normally have a high social competence, counselling and/or training education and the relevant experience cannot be compensated or replaced. Thus the EduCoRe counselling and training Kit targets trainers and counsellors who can either be internal (rehabilitation staff with the corresponding education in the field of counselling and training) or external (in terms of professional counsellors and trainers who work with the patients in a specific rehabilitation setting). The project team has the opinion that not only the patients but also the staff of medical rehabilitation centres benefit from this new project approach – As professionalism is guaranteed on all levels: the staff has no direct responsibility, but can contribute positively to the counselling and training process. At the same time, the patients (as final beneficiaries) can take part in a service conducted by professionals who in case of different situations (due to the emotional effect) know how to handle them.

1.2.2 The EduCoRe project's phases

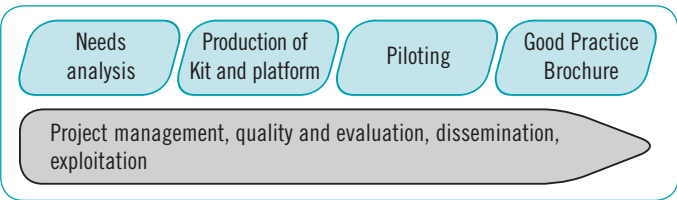


Fig. 3. EduCoRe project's phases

In the beginning of the project a needs analysis was conducted by all partner countries (Austria, Germany, Denmark, Italy and Slovenia). Patients as well as the staff of medical rehabilitation centres were questioned about the needs of patients whilst helping them to re-enter the labour market.

Based on the results of this needs analysis, a blended counselling and training service was developed and tested with the patients of rehabilitation centres in the partner countries.

The blended educational and vocational counselling and training services contain elements of e-counselling and e-Learning, as well as face-to-face sessions aimed at helping patients to:

- take thoroughly reflected career decisions
- identify the types of further education they need in their specific situation to improve their employability
- develop their personal and social competences which are necessary to put their professional and educational decisions into practice

Thus, medical rehabilitation patients might be able to reintegrate easier into the labour market and to actively participate in society after the period of medical rehabilitation.

During the testing phase of the material, in which patients of medical rehabilitation centres from Austria, Germany, Italy and Slovenia participated; feedback regarding the course was gathered by the participants as well as by the counsellors and trainers. Their critical feedback was factored in the finalisation of the counselling and training material, as well as in this brochure.

It was found during the project that management, quality and evaluation, dissemination and exploitation were essential factors regarding the achievement of the project aim.

1.2.3 Project partners

The EduCoRe project consortium consists of six partners from five European countries:

die Berater
Unternehmensberatungs GmbH
www.dieberater.com

die Berater® are a private company founded in 1998 with 480 members of staff who work in more than 60 locations all over Austria. The core fields of busi-

ness are education and training, coaching, outplacement and consultancy, and EU projects.

die Berater® develops and organise educational seminars and training courses for individuals, organisations, and enterprises. The main aim of these offers is to motivate and qualify customers to make full use of their potentials in the economy, at the labour market and in their personal lives. The company offers a wide range of training and education – from soft skills to languages and information technologies. Contents and methodologies are tailor-made according to the needs of customers. Fair play, respect, tolerance and social responsibility are central values of the company.



Donau-Universität Krems
www.donau-uni.ac.at

Danube University Krems is Europe's only state-run university for postgraduate education and combines high quality in education, research and consulting. More than 3,500 students from 50 countries are

enrolled in over 150 academic courses. Areas of competence include economics and management; communication, IT and media; medicine and health; law, administration and international relations; cultural and educational sciences; building and environment. In its research and training activities, the Department for Interactive Media and Educational Technology (IMB) focuses on the design, realisation and evaluation of didactic arrangements for technology supported learning with special focus set on the complex relations of face-to-face as well as face-to-interface (e-Learning) arrangements.



Århus social- og sundhedsskole
www.sosumedia.dk

Århus Social and Health Care College (Denmark) is a state-funded, self-governing institution with approximately 500 students per year and 115 employees in total. Its purpose is to offer short-cycle vocational

social and health care education and training and associated continuing training. A basic programme concerning these subjects is

offered for young people, immigrants and refugees. The college has its own web production unit, and it has developed a great expertise among web designers and teachers in the production of goal-directed teaching and knowledge mediating web sites. Furthermore the teachers at the college use web based teaching programmes to a large extent in the daily teaching and try to transform these competences to other target groups such as patients and clients in the treatment system.



Training 2000
www.training2000.it

Training 2000 is a VET organization, accredited for training in the Marche Region-Italy with experience in adult training and social-economic disadvantaged groups. Since 1994, Training 2000 has been involved in the

research and development of new tools and methodologies for LLL-LLP and distance learning as well as pedagogical aspects of teaching and learning in adult education. Training 2000 takes part in EU projects in subject areas related to formation, e-Learning/ blended learning, ICT and innovation, integration of disadvantaged groups in society and employment. Training 2000 is continuously promoting adult training for apprentices, employed, unemployed people, people in mountainous areas, and health care from regional hospitals. The activities are carried out in continuous cooperation with local government offices, associations, health departments, universities, trade unions, training organisations and social partners.

BUPNET

BUPNET – Bildung und
Projekt Netzwerk GmbH
www.bupnet.de

BUPNET, Training and Project Network Ltd., founded in 1985 is an adult education provider based in Germany accredited by the TÜV CERT – Certification Body of the Rheinland Group, according to the UNI EN ISO

9001:2000 and the AZWV – a special certification for training institutes working with the national unemployment office. BUPNET has successfully completed several training courses in various sectors (social sector, health care, eCommerce, tourism, environmental

economy, journalism, marketing/PR, new media and intercultural issues) both in the framework of European and national funded projects. BUPNET has developed its own multilingual eLearning platform which has successfully been tested in a LIFE Environment project and in different EU-projects on both a local and a regional level. For ten years, BUPNET has been working on large scale European education and employment programmes. BUPNET is a foundation member of the blended learning institutions' cooperative blinc.



Glotta Nova (Slovenia) is an international educational training centre with a strong domain expertise in soft skills, training and language teaching and serves European enterprises in their aim of achieving profes-

sional and personal excellence with their employees. Since 1992, when the company was established, experiences have been gained in the field of communications, rhetoric, sales & marketing, teambuilding, time management, languages, NLP and more. Delivering over 130 training years, the company has grown to establish a portfolio of long-term partnerships with different companies. Glotta Nova has acquired a reputation for quality, innovation, highly competent staff and a high commitment to customer satisfaction.

The EduCoRe approach is a blended one. This means that the service not only consists of face-to-face sessions, but also of e-Learning and e-counselling parts:

1.3 Blended learning approach

Blended learning is the combination of multiple approaches to learning in which the use of blended virtual and physical resources takes place. Normally blended learning is characterized by a combination of technology-based materials and face-to-face sessions used together to deliver instruction.

In the EduCoRe project, elements of e-counselling and e-Learning are integral parts of the blended learning service.

This choice of approach is based on the idea that information and communication technologies have a high potential for people who are restricted in their mobility or who change their location several times in the process of medical rehabilitation (hospital-home-rehabilitation centre-home).

A definition of e-Learning:⁷

“E-learning is a learner-focused approach to the use of new multimedia technologies and the internet to improve the quality of learning by facilitating access to resources and services, as well as remote exchanges and collaboration. A decade of experience in Europe has proven its value as an innovative tool for education and training.”

Fig. 4. Definition of e-Learning

E-learning enables patients to gain new knowledge whenever they want. Learning becomes possible at any time and place. With the help of computer based learning materials, participants of the counselling and training can deal with specific topics whenever they like.

The online modules of the EduCoRe project are designed as a self-learning course for an individual, with interaction in a group. They are specially designed to prepare, repeat or support the trainer-led sessions and are delivered on an e-Learning platform. Therefore an internet connection is always required.

⁷ <http://ec.europa.eu/education/lifelong-learning-programme/doc/sec2629.pdf>

The e-Learning platform should be introduced to the patients during a face-to-face session in order to make sure that all participants are familiar with its functions, thus being in a position to work with it individually. An introductory session is of utmost importance to avoid frustration among participants. Since technical questions are likely to occur throughout the counselling and training process. Time should always be given to tackle these questions during the face-to-face training, either individually or in the group. Ideally, the online learning is accompanied by a trainer or tutor, who is available for feedback and technical support.

Through computer-based counselling tools it is possible to provide support throughout the rehabilitation process, ideally starting in hospital and finishing when the patients return to their home after the rehabilitation centre.

Face-to-face sessions, as well as e-Learning and e-counselling are characterized by different factors as demonstrated in the following figure:

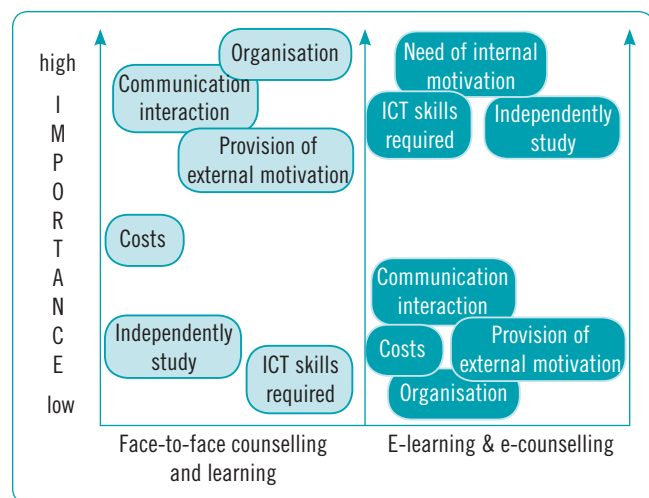


Fig. 5. Face-to-face counselling and learning versus e-Learning and e-counselling

This graphic should also demonstrate that face-to-face learning as well as e-Learning and e-counselling are related to similar factors, but their effects are different. As for example is communication and interaction between learners and other learners, or learners and trainer/counsellors. E-learning focuses very much on self-motivation and therefore self-study, while in the face-to-face sessions the trainer or counsellor is also some kind of external motivator for the participants. Although the computer has already taken a big part in one's daily life, not all people are familiar with its use or simply don't like to learn with it. Furthermore ICT support is not always given when needed. This means that a person who is not used to working with a computer might refuse to use it in terms of a learning mode, although experience has shown that, once patients know the structure of the e-Learning package, they feel more secure with handling the computer. They are more likely to discover themselves working at their own pace with the available online material. If this initial instruction is missing, patients tend rather not to revisit the e-Learning platform by themselves. The use of e-Learning tools throughout the course will help participants to improve their computer skills, thus enabling them to apply modern information and communication technology to their everyday work and in their further vocational development. This goes hand in hand with the Lisbon Council identified ICT as core components of the knowledge society and as a necessary instrument for adapting education and training systems to it.⁸ All these aspects have to be taken into consideration while planning a learning and counselling offer such as the EduCoRe one.

E-learning covers various learning and teaching scenarios using electronic media. Throughout the EduCoRe project, the e-Learning part consists of self-study units provided as texts, multi track tests, questionnaires, and wikis as well as video and audio files dealing with the five modules of the training and counselling programme.

⁸ <http://ec.europa.eu/education/lifelong-learning-programme/doc/sec2629.pdf>

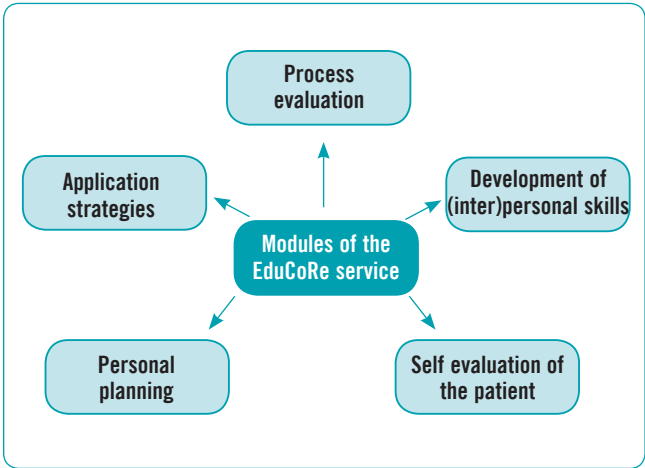


Fig. 6. Five modules of the EduCoRe Kit

These five modules are modular in terms of time. This ensures a flexibility and adoptability concerning the needs of the patients target group.

E-counselling, contrary to e-Learning, is special in terms of the electronic counselling situation between a counsellor and his/her client. There are different modes of online counselling. The most used in the EduCoRe context are:

- *E-mail*: the client writes a message to the counsellor regarding his/her situation or problem. The counsellor can then reply in order to help the client discover a solution. The benefit of this method is that it slows the whole process of counselling down, allowing time to consider issues and solutions more thoroughly.
- *Real-time interactions (in written)* in a chat room/instant messaging: client and counsellor meet in an online room where they write to each other. Here the client can receive instant feedback, much like in a face-to-face session.
- *Real-time interactions (oral)* in an online room, or in a Skype session: The procedure is similar to the previous mode but now clients and counsellors talk instead of write to each other in an online room.

Compared to face-to-face counselling, e-counselling has various advantages such as:

Advantages	Why?
<i>Online counselling as an alternative to traditional face-to-face counselling</i>	It can be a beneficial option for many people who are in need of counselling, but are either not up to meeting the counsellor or due to some reason don't want to meet them in the "real world".
<i>More time for reflection</i>	It gives time for reflection and can help people work through their thoughts and feelings more thoroughly than just talking about issues. Patients' responses are more thoughtful.
<i>Writing as alternative to express oneself</i>	Patients who have difficulties talking about their concerns face-to-face may find out that writing about them is easier for them. Sharing this with a counsellor online can lead to feedback which can help them resolve such issues.
<i>Negotiation of distance challenges</i>	Counselling can be provided for those who live at great distances from counselling locations. This counselling is flexible in relation to schedule and location (disabled, isolated patients).
<i>Choice of location</i>	The patients can decide the location.
<i>Counselling according to one's learning style</i>	If done in a well elaborated way, blended learning and e-counselling could also be a means to consider different learning styles, abilities and preferences.
<i>Reduction of pressure</i>	Online counselling eliminates the pressure to respond.

Fig. 7. Advantages of e-counselling

E-counselling can be understood as an alternative to face-to-face counselling. Never the less, there are some disadvantages which one has to be aware of:

Disadvantages	Why?
<i>Potential for misunderstanding due to lack of visual, auditory and paralinguistic cues</i>	With the exception of video-conferencing and to a certain extent Skype, online counselling lacks visual and/or auditory cues. Traditional counselling relies strongly on characteristics such as facial expression, body language, and eye contact, tone of voice and even periods of silence to communicate information that words may be unable to. Examples of non-verbal communication that the client would usually convey are: the person who speaks loudly and rapidly, but says they are relaxed, or the person who slumps in their seat looking dejected but says they are fine.
<i>Longer time needed for establishing a trustful relationship</i>	In a face-to-face meeting, it is in most cases easier for the patient to establish a trustful relationship to his/her counsellor than in virtual counselling sessions.
<i>Lack of privacy and confidentiality</i>	Internet communication may not be secure. Data that travels between the patient and the counsellor is exposed to potential hackers unless additional security measures are used. E-mail and instant messaging systems do not support authentication and encryption.
<i>Unreliably technology</i>	There is always a small chance that computers and computer networks may fail to deliver an acceptable level of service in areas such as response time or error rate or even sometimes fail completely. While an occasional missing e-mail would create some difficulties, disruption to chat or video sessions would be far more intrusive and potentially distressing for clients.

Fig. 8. Disadvantages of e-counselling

The authors are aware that the mentioned advantages and disadvantages are only the bare minimum of the total number of possible problems that could be experienced by both the client and counsellor. In the end, the client has to decide which counselling style he/she prefers respectively of which mode is more target-aimed. The following chapter deals with life in rehabilitation centres, regarding the uses of informal learning:

2. Life in Rehabilitation Centres

Sabine Wiemann, Elisabeth Frankus

2.1 Introduction to the background of rehabilitation

The word “rehabilitation” comes from the Latin „rehabilitare“ meaning to make fit again. In health care, rehabilitation provides interventions that go beyond medical treatment to help those with injuries and illnesses to re-establish themselves as productive and socially-integrated citizens. The overall goal of rehabilitation is to improve the patient's ability to function at home and in society in the face-of-the residual effects of the injury, which may be complex and multifaceted.

Yet the idea is not new – throughout human history, people have faced the uncertainties caused by unemployment, illness, disability, death and old age. As early as 1601, the English Poor Law was introduced and can be considered as the first systematic codification of the responsibility of the state to provide for the welfare of its citizens. Nonetheless, the concept of rehabilitation only took hold during the First World War when so many injured soldiers needed to become re-established upon their return home. Rehabilitation has always implied two imperatives: a moral one, which means that it is not enough to keep people who are ill or injured alive, but that their lives must be worth living, and an economic one, that is, to reduce the economic burden that people with disabilities have on society.⁹

9 Slack, P. (1990). The English Poor Law, 1531–1782. London: Macmillan

The UN World Programme of Action Concerning Disabled Persons was adopted in 1982 as a global strategy to prevent disability, promote rehabilitation, and provide for the full participation and equal opportunity of people with disabilities in social life. Emphasis has been placed on disability leadership training and self-advocacy. The World Health Organisation has taken a lead in funding international efforts including community-based rehabilitation programmes.¹⁰

The next chapter describes rehabilitation centre as a location for medical rehabilitation:

2.2 Rehabilitation processes

Rehabilitation centres are specialised in the rehabilitation of people who have experienced a disabling physical illness or injury. Rehabilitative activities take place in general hospitals or in specialised rehabilitation facilities, e.g. rehabilitation clinics, vocational training centres, or schools, and may take the form of inpatient treatment, day-care, or outpatient treatment for the assessment and treatment of people who have impairments. The rehabilitation centres are dedicated to providing care that focuses on the physical, psychological, social and spiritual needs of patients in an environment that fosters health and wellness. The main task consists of helping people to maximise their independence and also to re-adapt and re-build their lives.

Rehabilitation is important and often represents one of many steps in the recovery process for patients. According to disease patterns, patients may have to undergo a long recovery process, i.e. they may receive treatment and care in an intensive care unit of a hospital followed by movement to a sub-acute unit. Once medically stable, the patient may be transferred to a long-term acute care facility, to a rehabilitation inpatient treatment unit or to an independent off-site rehabilitation centre. Decisions regarding when and where an

individual should be treated at a particular point during the recovery process are complex and depend on many different factors, including the level to which the person can be engaged actively and to what degree the individual can participate in the rehabilitation process.

There is a general tendency to avoid long inpatient treatment phases and preference is given to outpatient treatment that allows patients to return to their familiar environment. During the outpatient phase of care, goals often shift from assisting the person and achieving independence regarding the basic routines of daily living to assessing the patient and treating the broader psychosocial issues associated with long-term adjustment and reintegration into the community. Therapists help the patient adapt to disabilities or change the patient's living space and conditions to make everyday activities easier, but also to help the patient adjust to the remaining impairments. During the adjustment phase, patients may have problems as they become increasingly aware of their residual deficits and face the challenges of coming to terms with the long-term effects of their injury or illness and of being able to resume expected social roles.

The rehabilitation process can be of a short or long duration. Once patients are medically stabilised, they may begin to think about returning to work. The rehabilitation team consists generally of professionals who support the reintegration process by developing an action plan that ensures a successful and safe reintegration back to work. As the medical condition improves, work reintegration focuses on closing any gaps between functional (physical and mental) capabilities and the specific demands of occupation. The rehabilitation specialist coordinates this process with patients.

The reintegration is composed of the following (exemplary) elements:

- Gaining a better understanding of functional capabilities, current status and identifying any potential barriers requiring assistance for returning to work,
- identifying potential activities that will contribute to maintaining essential skills required for continuing with the former occupation,

¹⁰ Duncan, B. (Ed.). (1992, September). International rehabilitation review (Vol. 43, No. 1). New York: Rehabilitation International

- developing a return to work plan,
- visiting and discussing the plan with the employer which also includes determining how potential barriers at work can be accommodated and whether these are on a temporary or a permanent basis,
- reviewing the proposed plan for work re-entry with the treating physician and, where applicable, with other key parties (according to national legal principles),
- finalising the rehabilitation plan with a start and anticipated end date for the return to work.

Typically, the rehabilitation plan is focused on enabling patients to return to their own occupation where they have the most experience and knowledge of the workplace and their job. If patients are unable to do so due to functional limitations, but can return to other employment, then it has to be determined whether other opportunities exist within the former company. Beyond this, alternative options can be considered once the previous options have been fully explored.

2.3 Role of rehabilitation staff

Moderately to severely injured patients may receive specialised rehabilitation treatment provided by a team of specialists from different areas, such as physical therapy, occupational therapy,



Fig. 9. Patient centred rehabilitation

speech/language therapy, psychology, psychiatry, and social work, among others. The services and efforts of this team of healthcare professionals – whose skills are needed to achieve favourable patient outcomes – are generally applied to the practical concerns of and the pragmatic problems encountered by the patients.

The treatment programmes generally keep the primary focus on the overarching goal of optimising patient function and independence through the coordinated application of discipline-specific expertise. Several different disciplines may be treating a patient simultaneously, thus making coordination and team work extremely important. But apart from the professional aspect, there is the emotional aspect which may be of equal or even higher importance for the patients' recovery.

Apart from the professional competence patients expect from health professionals, patients expect a relationship built on trust. Due to their illness or injury, they find themselves in a vulnerable situation in which their physical, emotional, intellectual, social, or spiritual functioning is altered or diminished. According to their own personality, social and cultural environment, each patient has a very individual way of coping with illness or injury and its consequences that may alter the way of living partially or even radically. In addition to that, the rehabilitation process often takes place in an unfamiliar context showing significant differences from the usual life of the patient. Patients need to adapt to a temporary setting, which seems at first unknown and very different from normal life. Or, depending on the illness or injury, people are forced to alternate between their homes and the rehabilitation centre, which means a temporary break from one's regular routine.

Against this background, it seems obvious that the relationship patients may develop with health professionals is an important one and influences the patients' emotional state for better or worse. The relationship they have may affect their condition and how they perceive it. Staff makes a huge impact on the patients' experience while in care. A well-trained, caring staff of experts can make a significant impact on the life of the recovering patient and help them during the recovery process after their illness or injury. Above all, for patients

undergoing inpatient treatment or long-term care a large part of their world are their health professionals. Thus, the quality of their relationships with care providers is strictly connected to their quality of life. This is why caring staff should be able to stabilise and handle patients' emotions and to help them acquire the attitudes and basic skills needed to face and accept their new condition during their stay in rehabilitation, as well as after their return home.

In the background of these explanations about medical rehabilitation centres, patients who spent several weeks or months in such institutions represent a specific group of adult learners:

2.4 Patients as adult learners

A patient is any person who receives medical attention, care, or treatment. The person is most often ill or injured and in need of treatment by a physician or other health care professional, although one who is visiting a physician for a routine check-up may also be viewed as a patient. A distinction between outpatients and inpatients is made: An *outpatient* is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Treatment provided in this fashion is called ambulatory care. Outpatient surgery eliminates inpatient hospital admission, reduces the amount of medication prescribed, and uses a doctor's time more efficiently. More procedures are now being performed in a surgeon's office, termed office-based surgery, rather than in an operating room. Outpatient surgery is suited best for healthy people undergoing minor or intermediate procedures (limited urologic, ophthalmologic, or ear, nose, and throat procedures and procedures involving the extremities).

An *inpatient* on the other hand is „admitted“ to the hospital and stays overnight or for an indeterminate time, usually several days or weeks (though some cases, like coma patients, could be in hospitals for years).¹¹

¹¹ <http://en.wikipedia.org/wiki/Patient>

Patients – independently of which medical institutions they attend – are part of a system which is constituted of different (daily) routines such as medical and psychological treatments.¹² Making use of “unused time in between treatments and doctor consultations” for learning activities is the main idea of the EduCoRe project: A counselling and training offer conducted by professional counsellors and trainers can be integrated in the existing circumstances of the patient, aimed at supporting patients in finding a way back to their social and work life. Based on the experiences gained in eHospital¹³ and on the basic principals of adult learning by Peterson/Clark/Dickson (1990),¹⁴ the following recommendations have to be kept in mind during learning activities in medical rehabilitation centres:

- Adults are motivated to learn when they discover that their needs can be satisfied through learning. Therefore it is important to base the counselling and learning offer on the patients' needs.
- The analysis of one's own experience is a valuable resource for learning. As from this starting point, the learner establishes his/her own needs. For this, the programme offers the possibility to select one's own learning pathway.
- Individual differences increase with age. Older adults have more defined learning styles, and they have usually acquired some intellectual working competences. This learning group has more clearly defined preferences and expectations. Autonomous learning should therefore be a priority.
- Some adults don't have any experience in learning with new technologies. Therefore, they may not be very happy with e-Learning and e-counselling during the early stages. These barriers have to be handled with the support of the counselling and training staff who will work with the patients of the medical rehabilitation centres.

¹² Hurrelmann, K. (2006, 6th edition), *Gesundheitssoziologie. Eine Einführung in sozialwissenschaftliche Theorien von Krankheitsprävention und Gesundheitsförderung*. Juventa, Munich, 92

¹³ Bienze, H. (2008), *eHospital: Experiences with E-Learning Activities for Patients*, “die Berater” Unternehmensberatungsgesellschaft mbH

¹⁴ Peterson, P.; Clark, C., Dickson W. (1990). *Educational Psychology as a Foundation in Teacher Education: Reforming an Old Notion*, in Tozer, S., Anderson, T., Armbruster, B. (Eds): *Foundational Studies in Teacher Education. A Re-examination*, New York, Teacher College Press, 24–48.

tre. They have to explain to the patient how to use the computer, give advice concerning technology, deal with their concerns and worries and also motivate them for their period of self study.

Also, the right moment to begin the counselling and training has to be detected for each patient individually: First a person has to accept his/her new situation before thinking of returning to work. Therefore the following section deals with the different stages of acceptance.

2.4.1 Stages of acceptance

An accident or illness can cause different physical or psychological consequences for one's life. Apart from one's physical rehabilitation, it can take time until a person is able to accept his/her new situation, which is often characterized by some sort of limitation(s) or changes compared to the time before the accident or illness.

Patients undergo different stages of acceptance until they find a way to deal with their new life situation. This process of acceptance is comparable with the first five stages of grief by Elisabeth Kübler-Ross:¹⁵

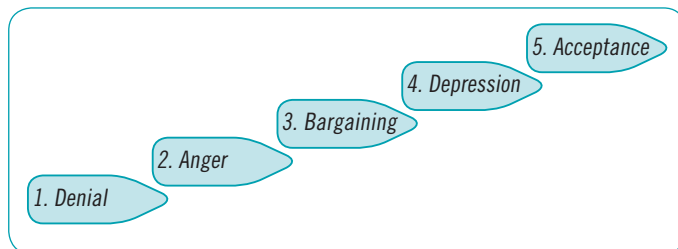


Fig. 10. Stages of grief

- **Denial:** Denial is a conscious or unconscious refusal to accept facts, information, reality, etc., relating to the situation concerned. It's a defence mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be temporarily ignored.

- **Anger:** Anger can manifest itself in different ways. People dealing with emotional upset, which is very often a side effect of a change, caused by an accident or illness, can be angry with themselves, and/or with others, especially those close to them. In this stage it might be difficult for certain staff to get in close contact with the patient.
- **Bargaining:** Traditionally the bargaining stage for people facing a new life situation can involve attempting to bargain with whatever God the person believes in. This third stage involves the hope that the patient can somehow "go back to his/her former life".
- **Depression:** In this phase the patient accepts his/her new life situation with all its consequences with emotional attachment. It's natural to feel sadness and regret, fear, uncertainty, etc. It shows that the person has at least begun to accept the reality. Still it is too early to begin with counselling and training aiming at reintegration into the labour market.
- **Acceptance:** Compared with the 4th stage the patient is now able to accept his/her new life situation. In this phase, he/she is (more) open to external help in the sense of participating in the EduCoRe project's counselling and training offer.

The patient has to be in the phase of acceptance before working on his/her vocational and social comeback.

2.5 Prerequisites for the integration of training and counselling modules for rehabilitation centres

Different illness groups receive various forms of medical rehabilitation, such as orthopaedic, neurological or cardiac rehabilitation. In addition, special needs, for example of geriatric patients or children have to be taken into consideration. For this rehabilitation centres are generally specialised and provide interventions in specific fields. When organising a training and counselling programme in rehab, both organisational conditions inherent for each rehabilitation centre include issues related to rehab routines (timetables, treatments, tests...) and the individual

¹⁵ Kübler-Ross, E. (1969), On Death and Dying

conditions of the patients need to be considered. Patients need to be medically and emotionally stabilised and prepared to think about their re-entry into the world of work before entering in a vocational and educational training and counselling situation like the one that was offered in the framework of the EduCoRe project. During the implementation of the programme, possible crisis situations may arise and may influence, disrupt or even stop the counselling and learning process. Trainers may be confronted with extreme situations in which patients have to cope with dramatic changes in their own life situation, e.g. loss of mobility after a spinal cord injury, and should be able to react accordingly, adapting the programme to the particular necessities of the patient. Needless to say, the trainer's role is extremely difficult in such cases because the patient goes through different stages with fluctuations in the evolution of an illness or injury. Therefore specific requirements are necessary for trainers and counsellors who work with patients. These are discussed in chapter 3 of this brochure.

In such a context, the training and counselling offer should contribute to the improvement of the patient's quality of life and promote their personal and emotional growth.

Apart from the medical and emotional status of the patient, organisational aspects in the rehabilitation centre influence the training and counselling setting.

The trainer and counsellor who undertake the work in the rehabilitation environment have to know the organisational logic and processes and also need additional information about each patient interested in par-

ticipating in the programme. For ensuring that the training and counselling is beneficial for the patient, trainers and counsellors have to be supported by the rehabilitation centre staff who should on their part be continuously informed about the training and counselling processes.

A continuous exchange and communication are of utmost importance throughout the whole process.

2.5.1 The Learning setting

The EduCoRe training is based on a combination of technology-based materials delivered on an e-Learning platform and face-to-face sessions delivered in a classroom situation. The online modules are designed as a self-learning course for an individual, and also with interaction in a group. They are specially designed to prepare, repeat or support the trainer-led sessions and are delivered on an e-Learning platform. Therefore an Internet connection is always required.

The e-Learning platform should be introduced to the patients during a face-to-face session in order to make sure that all participants are familiar with its functions, thus being in a position to work with it individually. An introductory session is of utmost importance to avoid frustration among participants. Since technical questions are likely to occur throughout the counselling and training process, time should always be given to tackling those questions during the face-to-face training either individually or in the group. Ideally, the online learning is accompanied by a trainer or tutor, who is available for feedback and technical support.

Experience has shown that, once patients know the structure of the e-Learning package and feel more secure with handling the computer, they are more likely to discover themselves working at their own pace with the available online material. If this initial instruction is missing, patients tend not to revisit the e-Learning platform by themselves. The use of e-Learning tools throughout the course will help participants improve their computer skills, thus enabling them to apply modern information and communication technology to their everyday work and in their further vocational development.

To further promote the use of e-Learning modules, the trainer who delivers the face-to-face session should try to bridge the face-to-face

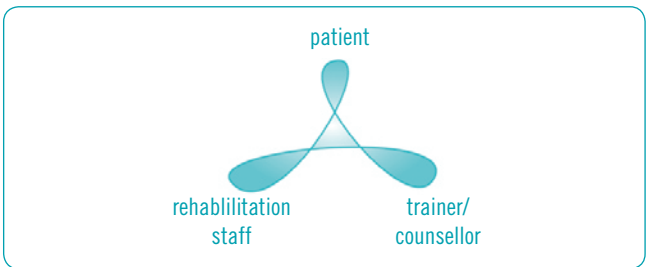


Fig. 11. Cooperation between patient, rehabilitation staff and trainer/counsellor

exercises to the e-Learning modules by referring, where suitable, to the online learning units and by including findings, questions or any kind of feedback in his/her training session.

3. Counsellors and trainers working with patients of medical rehabilitation centers

Elisabeth Frankus, Bodil Mygind Madsen,
Niels Christian F. Vestergaard

3.1 Counselling and training in rehabilitation centres in regard to job orientation

There are various assumptions underlying the practice of career counselling and training. Some of them are that people have the ability and opportunity to make career choices for their lives and that individuals are naturally presented with career choices throughout their lives.

The amount of freedom of choice is partially dependent upon the social, economic, and cultural context of the individual, but opportunities and choices should be available for all people, regardless of sex, socio-economic class, religion, disability, sexual orientation, age, or cultural background.¹⁶

When it comes to patients with physical and/or physiological deficiencies after an accident or illness that threatens their employability and participation in society, professional re-orientation is no longer a matter of free choice, but a sheer necessity. A change in one's life situation causes a need for change in career. In order to make decisions about new career pathways, information about career pos-

As mentioned above, the counsellors and trainers collaborating with patients in medical rehabilitation centres are assigned specific roles which will be discussed in the following chapter:

sibilities and educational institutions (as well as support in decision-making) is both necessary and crucial.

Modern societies have well developed systems of bodies and services offering job / education orientation and career counselling to their citizens. In many cases, however, this counselling is given only after a stay in a medical rehabilitation centre – and this phase can be of a long duration.

By offering job orientation while the patient is still in the rehabilitation centre (conducted by professional counsellors and trainers), it is possible to start the process of vocational reorientation at an early stage and make better use of the time at the centre. During the rehabilitation phase, periods without treatment or therapy can be used with benefit for vocational counselling, e-counselling and group trainings on the topic. In this sense the physical rehabilitation is accompanied by “occupational rehabilitation”. The length of this period depends on a number of different conditions: not only physical state of the patients, but also the national rehabilitation system. In some countries the medical rehabilitation process lasts longer than in others. Some patients don't want to think about their future working life, although physical preconditions are given in terms of physical working conditions. They haven't reached the moment yet where they want to return to labour market. Thus, the start of the vocational rehabilitation has to fit in with the patient's needs and demands. It wouldn't make sense to start too early with the vocational comeback, as this could cause more discouragement than motivation.

Defining and starting the occupational counselling and training process at the right time prepares the patient for the occupational guidance that normally follows their rehabilitation. This, in the long run makes the reintegration into the labour market easier.

¹⁶ From UNESCO's Handbook on career counseling

Widening and reflecting on our perspectives automatically directs attention to the future, thus promoting (not only the orientation towards change, but also) the recovery of the patient and supporting the medical rehabilitation process. One big advantage of the EduCoRe project is that the close cooperation between the staff of the rehabilitation centre and the professional trainers and counsellors (who can be rehab internal or external) means that staff trained and educated in counselling and training can conduct the EduCoRe offer also. This frequent exchange of (medical) information ensures that the counsellors and trainers not only know the patients' medical condition, but can also estimate patients' future abilities to cope with certain job-related activities.

The EduCoRe offer aims at not only reintegrating people into the labour market, but also at promoting the idea of life long learning, which is one of the main aims of the European Commission. Career counselling and training in rehabilitation centres goes hand in hand with this aim. Especially when attention to these four points is drawn:¹⁷

- Promoting adult learning,
- Widening access
- Increasing participation
- A learner-centred approach coupled with open and flexible forms of learning.

3.2 The role of counsellors and trainers

Professional secrecy is a basic rule in counselling and training, which is regulated by law in most European societies.

The role of the counsellor and trainer requires a constant awareness of professionalism and ethics. This implies the following principles:

- *Professional relationship*: It has to be clear that professionalism is not the same as “emotional galvanisation” – which means lack

of emphatic capability. Empathy is an essential part of the professionalism of a counsellor or trainer.

Counselling and training are professions where one must be aware that one's own “good ideas”, sympathies and prejudices do not influence the process and the result of the counselling.

- *Discretion*: It might happen that the counsellor and/or the trainer get information about irregularities or even illegalities, which can be difficult to handle. In general the counsellor and the trainer have to maintain discretion, although in extreme situations there are exceptions which will not be listed here.
- *Internal dilemma*: It is not always easy or even possible to judge what is objectively good for a patient after one or more counselling session/s. So the counsellor and trainer need to have patience when developing a holistic picture of the patient's current situation. Counsellors and trainers have to be aware that in some counselling and training situations they will unintentionally bring in their own personal views.
- *Accompaniment*: Neither a counsellor nor a trainer is responsible for solving the patients' problems. Essentially, counselling is about making the patients see new possibilities and making them aware of resources they had forgotten about or had never recognized. Furthermore, both counselling and training are about preparing the ground for helping the patient understand himself or herself better and to see the new possibilities for himself or herself while supporting him/her during this process. But neither of these two processes are about telling people what to do, or about what a counsellor or trainer thinks they should do. This means that a counsellor or trainer should never make the decisions but support the patient's decision-making process.
- *Sympathy versus dislike*: There will be cases where the counsellor and/or trainer do not sympathize with the patient they are working with – or even dislikes him/her. But every patient has the same right to receive the optimal treatment or service. In cases where dislike becomes a problem, the counsellor and/or trainer should hand the patient over to another counsellor and/or trainer.

¹⁷ Communication from the Commission of 21.11.2001: Making a European Area of Lifelong Learning a Reality (COM(2001) 678 final)

It is important for the counsellor to maintain professionalism during the training process. Beside the already mentioned aspects, the following requirements for counsellors and trainers working in the EduCoRe context have also to be taken into consideration:

3.2.1 Requirements for counsellors and trainers in the EduCoRe context

Some countries have specific counselling courses respectively shorter or longer for trainee counsellors. In many cases, however, persons not educated or trained for counselling end up filling such roles. Often people with different educational and professional backgrounds end up managing the profession, for instance social workers, psychologist, teachers and pedagogues. They are providing vocational counselling without having been introduced systematically to counselling theories and practical counselling tools. It means that counsellors form a very inhomogeneous group when it comes to professional background and qualifications.

The EduCoRe project team are in agreement that uneducated and untrained counsellors and trainers should not work with the patient target groups. Not only because it would not be professional out of a counsellor's or trainer's point of view, but also because these persons face specifically difficult situations which a person without the required education may not be able to handle. Vocational and educational counselling and training have to be conducted by therefore trained personnel.

Never the less the following requirements for counsellors and trainers working with patients were summed by the EduCoRe project team:

3.2.1.1 Required hard skills for vocational and educational counsellors and trainers working with patients in the EduCoRe context

Knowledge about labour market and application strategies:
Any career counsellor or trainer should have solid knowledge about the labour market, including knowledge about job opportunities and job

openings at local, national and – to a certain degree – international level. They should be able to inform people about training opportunities. A counsellor and/or a trainer who is accompanying people through rehabilitation should furthermore know about the different consequences of reduced working capacity and also be familiar with all the economic and practical possibilities for compensation in relation to handicaps in the labour market and in the qualification and training system. Finally, the counsellor and the trainer should be able to mediate this knowledge to the patient in a clear and understandable way.

As already mentioned, counsellors and trainers in the EduCoRe context can face extreme situations like a degenerative illness, dramatic changes in their living situation or other fatal problems. Hence, the counselling and training aims at contributing to the improvement of the patients' quality of life and their personal and emotional growth. The counsellor's as well as the trainer's role are extremely difficult in such serious cases because the patient goes through different stages in the evolution of the illness. There is also the possibility of relapse. These situations are not always easy to cope with, as they require a large extent of emotional control. On some occasions, it may also be necessary to seek some type of psychological support or supervision.

Counsellors and trainers need the described hard skills (knowledge about the labour market and the economical and practical possibilities for compensation in relations to handicaps on the labour market and in the educational system), but also the so-called soft skills: Patients should get motivated and encouraged during this phase of counselling and training, which is very useful in a time of illness and pleasant for the patient. Therefore the counsellor and trainer have to have specific soft skills:

3.2.1.2 Required soft skills for vocational and educational counsellors and trainers working with patients in the EduCoRe context

Soft skills refer to the cluster of personality traits, social graces, communication, language, personal habits, friendliness and optimism that mark us.

Some essential soft skills for counsellors and trainers are self-observation, self-efficacy, self-confidence, self-esteem as well as appreciation.

As a condition for a fruitful communication between the patient and the counsellor, the trainer will have to be able to:

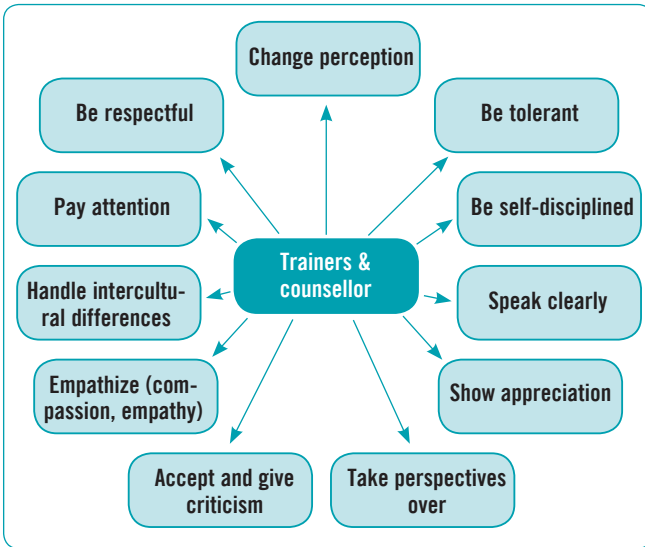


Fig. 12. Soft skills for trainers and counsellors related to other persons

Counselling and training activities include cooperation with other professionals and maybe with relatives of the patient – counsellor and trainer are not working in isolation with the patient – many other stakeholders can be involved in the process.

In terms of cooperation, counsellors and trainers need skills related to team work and cooperation, motivation, communication and conflict management.

The counsellor and the trainer have to frequently exchange crucial information with the medical staff of the rehabilitation centres such as doctors, physiotherapists, nurses, etc. but also with staff

members who care for the patient’s psychological well-being such as social workers, psycho therapists, etc. The cooperation between the counsellors, trainers and the other staff of the medical rehabilitation centre requires flexibility, exemplary behaviour, responsibility, consequence, generosity and assertiveness.

Both, counsellor and trainer have to have emotional intelligence and commitment. This includes the ability to reflect on one’s own thoughts and actions as well as others’.

Especially the trainer has to take into consideration that the size of the learning group can have a crucial impact on the group process. Learning is often accompanied by emotions. This means that facing new, unfamiliar situations can cause emotions and uneasiness amongst patients. In this case, bigger groups can make participants feel even more uncomfortable.

It is useful to use so called “ice braking exercises” to reduce stress and feelings of worry among participants and to ensure actively participation.

Trainers and counsellors in general have to be aware that the EduCoRe counselling and training offer is composed not only of face-to-face counselling and training but also of e-Learning units and e-counselling. Due to this fact, the counsellor and trainer are ideally e-Learning trainers or at least have an idea how to use the moodle platform which contains the exercises as well as the e-counselling environment. Patients have to be motivated frequently to use the e-Learning and e-counselling offer in order to deepen the skills and competences that they have learned during the face-to-face sessions. Making use of this additional service can help the learners reintegrate easier into the labour market and social society. To provide a feasible interlinking process between the face-to-face units and the e-Learning components, the trainer and the counsellor have to have a clear picture of the e-Learning and e-counselling offer. If needed, the counsellor or trainer has to know how to install an e-mail account for the patient.

The authors are completely aware that many different counselling and training approaches exist. Nevertheless, the following chapter contains a description of a counselling model, so that project managers or other individuals who would like to implement such or a similar training offer in a medical rehabilitation context can get an idea of how the counselling could work. Thus, the following five-step counselling approach can be seen as one out of many diverse models.

3.2.2 The five steps of counselling

It is the counsellor's task to organize a systematic process of counselling and ensure that it leads to results. The following "5-step" model is a proposal of how the counsellor could plan and carry out processes of counselling. The 5-step model is presented in "Femmeren – en vejledningsmetodik".¹⁸ It is used by many counsellors in Europe, especially in Denmark and Sweden where vocational counselling after and/or during medical rehabilitation already takes place in specific vocational rehabilitation centres. This approach has been a source of inspiration for this chapter, but it has to be understood as just one example out of many counselling methodologies.

The following figure gives an overview of the 5 steps which will be described in greater detail:

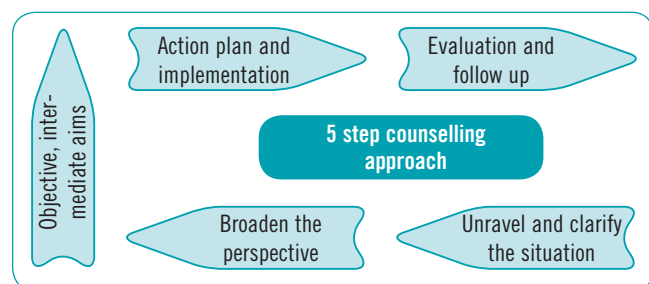


Fig. 13. 5 step counselling approach

3.2.2.1 Step 1: To unravel and clarify the situation

An insufficient description of a problem makes problem solving difficult or even impossible, and could imply that the "wrong" problem is solved. Therefore, it is essential that the counsellor and the rehabilitating individual take the time to clarify the situation and understand the relevant problems. An individual who has undergone an illness or accident (implying a new/changed condition of health and living situation) has an urgent need to clarify his/her new situation in life. Strengths as well as weaknesses must be included in this.

Questions that can be used during this step can be:

- Which changes have been detected in relation to competences and qualifications?
- Which tasks are impossible to perform, and which tasks can be fulfilled to a lesser extent?

A counsellor must be careful not to be too eager with solving a person's problems in which case he/she risks blocking the patient's own solution or progress.

It is important that the counsellor is well prepared for the first consultation and is updated concerning case notes and medical records. A person who has undergone hospitalization and rehabilitation courses has had to explain his/her situation many times before various professionals, and is often fatigued with having to do it again. Thus it is easy for the patient to misunderstand such behaviour as a lack of respect if the counsellor is not familiarized with his/her specific case. Nevertheless, if the counselor wants the patient to tell his/her "story" again (as falsification can happen if information comes from a third hand source), it is important that he/she makes his purpose clear.

As mentioned before, it is crucial that during the preparation, the counsellor does not develop a preconceived attitude or prejudices concerning the patient who is about to receive counselling.

It gives a feeling of security to clarify the scope of the consultation at the beginning, e.g. by informing the patient that the counsellor is sworn to professional secrecy, what the purpose of the consultation

18 Lindh, G. (2000). The five – a counselling methodology

is, what the counsellor's task is, and how long the consultation is appointed for.

Questions: In order to clarify the patient's situation, it is necessary to get the patient to talk. The counsellor can start this process by asking questions. There are different types of questions namely closed and open questions.

Open questions are questions that encourage the patient to tell more (E. g. questions starting with "how" and "what"). A special type of open questions is the so-called broad and descriptive questions. Starting with an introduction and ending with an encouragement towards the patient to state his attitudes and/or opinions about the stated. *Closed questions* are questions that are answered by "yes" or "no", or questions intended to bring out facts (Are you married? Where do you live? How many jobs have you had during the past 5 years etc? Specific types of closed questions are *leading questions*, which encourage the patient to agree rather than to activate own thoughts, e. g. questions like "Are you sad you lost your job?"

Reflection: During the process of the counselling, it is important that the counsellor reflects upon what is heard. Reflection means explain-

ing with one's own words how one understands what has been said. In this sense, reflection ensures a concord between what the patient has explained and how this has been understood by the counsellor. This gain prevents the counselling from going awry.

Summing up: During this step of the counselling process, it is the counsellor's task to help the patient gain an overview (as well as a thorough understanding) of his/her situation after the accident/ illness. The summing up has not solely to be done at the end of the consultation, but also during the course of the consultation if the patient goes from one subject to another, or if a subject is finished.

To create clarity: To create clarity, also clarity in language, to concretize, and to *focus*, are other issues that the counsellor has to be aware of during the counselling process. It might be of great help for some patients if the counsellor is able to visualize by making drawings on paper that illustrate, for example, the positions of persons/institutions influencing the patient's situation, the different barriers that they are facing or the opportunities he/she has. Equally, it can help a patient if the counsellor writes down some keywords during the counselling process and repeats them at the end of the session.

3.2.2.2 Step 2: To broaden the perspective

After a major life-changing experience, it is essential for a person undergoing rehabilitation to develop new perspectives and new angles in relation to his/her situation. In order to make this possible, the counsellor should be able to give them new knowledge as well as impulses and assist them in the restructuring and possible altering of existing knowledge. In other words, the counsellor has to inform.

To inform: As already mentioned, the counsellor has to have knowledge regarding labour market dynamics, as well as its possibilities and requirements. He/she needs to have knowledge of job openings, bottlenecks as well as contents of jobs. The same person should be knowledgeable about the area of education in question and familiar with all of the economic and practical possibilities for compensa-

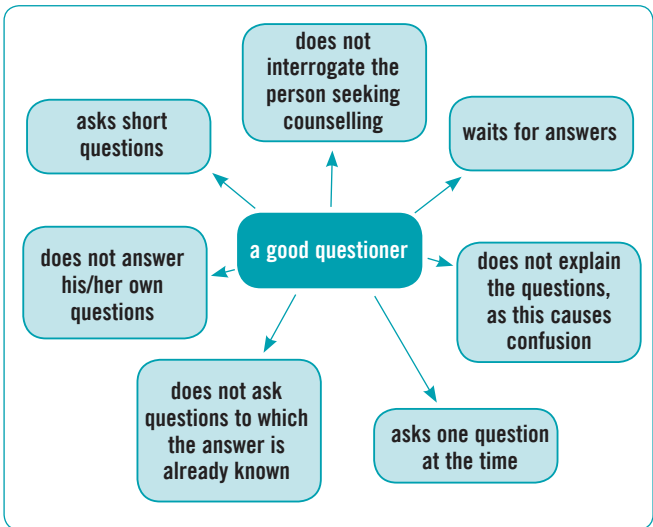


Fig. 14. Skills for a good questioner

tion in relation to handicaps on the labour market and within the educational system.

This knowledge is mediated to the patient during the counselling. It tends to develop the horizon and perspectives of the patient.

It is motivating, and it gives the patient an actual feeling of influence on (or more power in relation to) one's own situation if the counsellor does not "serve" the knowledge to the rehabilitating person but rather involves the patient in the examinations and is able to e.g. organize visits to educational institutions and practical training. In any individual case, the counsellor has to estimate to what extent the patient can be involved.

To provide information is not the same as giving advice. The patient, and not the counsellor, has full responsibility for making the choices that are influenced by the information given.

To confront: It is a painful process to realize that one is not able to maintain the same conception of oneself after an accident or illness, and having to relate to new perspectives regarding one's own situation can often lead to fear and resistance towards change. Based on the exchange process with the medical and psychological staff of the rehabilitation centre, the counsellor has – if necessary – to confront the patient with his/her (physical and/or psychical) limitations. This sort of confrontation is needed when the counsellor becomes aware that there are contrasts in e.g.: What the patient does and what he/she says. What his/her view of him-/herself is and what their views of others are. What he/she wants to become and what is possible due to his/her physical and/or psychological limitations.

If the counsellor does not carry through the necessary confrontations but merely agrees with the person in question, he/she counteracts broadening the patient's perspectives.

Confrontation must be carried out in a way that the initiative lies with the patient *after* the confrontation.

3.2.2.3 Step 3: To formulate objective and intermediate aims

After getting a clear idea of the life situation after the illness or accident – and thus developing new perspectives, the basis has

been created to find out *what* to do next – in other words to set aims and intermediate aims. The aims must be formulated before action is taken. The process of setting goals must begin by preparing a problem formulation.

Clear and concrete aims: Setting one's aims is about determining *what* has to be done and initially (in order to clarify) this must be separated from *how* one can do it. The rehabilitating person often has wishes for the future, and the counsellor must support him/her in reshaping these wishes into aims and intermediate aims that are concrete, specifically formulated and obtainable.

Adequate aims: The set aims must be adapted to the situation of the patient, and they must contain a solution to the problems arising as a consequence of the event that has occurred in the patient's life. In other words, the aims must contribute to the solution of the problem(s) described in the problem formulation.

Measurable and verifiable aims: It is necessary for the patient's motivation, that he/she is able to check if his/her aims are reached. Here it is not solely the case of quantitative, but also qualitative measuring.

Realistic aims: Aims must be realistic. There might be aims that live up to the above criteria, but don't help if the necessary resources of reaching them are not present i.e. if the costs are too high, if external circumstances hinder the fulfilling of these aims, or if the aim is beyond one's control. In the case of persons with functional handicaps after an illness or accident, it is essential that the person in question relates to the aims in relations to his/her present situation, and not the situation as it was before the illness/accident.

In the process of formulating aims, it is important to create alternatives to the aims (solutions) that the counselling person can discuss with the patient. For each alternative, it is important to create a *list of pros and cons*. In connection with starting any new job or course, there are pros and cons, and it is important to create a list of these

so that the rehabilitating person is able to evaluate their own position. After an illness or accident, new factors are present, which the person in question is not used to. When one considers the alternatives in connection with formulating one's aims, the counsellor may include the social environment for this step (inviting partner, family members and/or friends either in real world or in terms of imaginary exercises).

Persons who unintentionally have to change their career due to an accident or illness may find it difficult to see new possibilities, in which case it may be relevant to introduce methods such as *brainstorming* in order to bring out more possibilities.

At this point, it is essential that the counsellor does not settle with the fact that aims and intermediate aims have now been formulated, but that he/she continues with the next step of the counselling process and thus also supports the patient in reaching this aims.

3.2.2.4 Step 4: To prepare an action plan and to implement it

After having unravelled and clarified the situation after an illness or accident, and after having broadened the perspective and formulated the aims and intermediate aims, the preparations should be made for the rehabilitating person to work out a strategy or an action plan in relation to the labour market return (either directly afterwards or after re-training or education).

By identifying various alternative actions and preparing an action plan, the patient will become aware of *how* he/she can reach his/her aims, and *when*.

There are always several roads that lead to the same aim, but most people settle for the first road they see. Therefore it is important that the counsellor supports the patient in finding as many roads as possible for reaching the aim, so that the patient can choose the one most suitable for his/her situation, and have the others as alternatives if problems should arise in connection with "Plan A".

In addition, a time schedule must be worked out stating the order of, and the time when the different tasks have to be done. In connection with the preparation of an action plan, it is possible to use all the techniques already mentioned in relations to prior steps.

3.2.2.5 Step 5: To evaluate and follow up

Evaluation of the counselling process (and the results of the counselling) helps to ensure that the counselling person provides a counselling that is relevant for the patient who has undergone an illness or accident and now needs support in returning to the labour market.

The evaluation will make the patient receiving the counselling more aware of what goes on during the counselling, and clarifies the progress that has been made and how. It is quite simple to evaluate whether the aims have been reached in the end, but a continuous and systematic evaluation can help ensure that the counsellor constantly provides the most beneficial counselling for the specific patient in question. En route, by evaluation, it is possible to get an answer to e.g. if the counsellor is talking about the issues that the patient had intended to talk about, and whether the patient thinks that he/she is getting help with the issues that he/she wants to. After each consultation the counsellor can attempt to get an answer as to whether the counselling that has taken place on that day has helped to bring the patient closer to education or a job – e.g. with the help of a scale from 0 to 10 – where 0 can mean not at all and 10 absolutely (the scaling can be set individually).

Apart from letting the patient evaluate the counsellor, it is possible, for the counsellor to ask staff members of the medical rehabilitation centre to evaluate the counselling process from their perspective (Did doctors, nurses, social workers etc. recognize a change in the patient? Does he/she talk about his/her new aims? Etc.). Furthermore the counsellor can do self-evaluation e.g. with the help of a questionnaire.

The EduCoRe approach is, as mentioned before, a blended one. This means that face-to-face interactions are accompanied by e-Learning tasks.

E-counselling as a specific form of counselling, which is used in the EduCoRe project, which due to the circumstances (access to compu-

ter and internet, need of the patients, lack of time for “real” appointments from the counselling person, anonymity etc.) is described in chapter 2.2.

4. Piloting experiences from the EduCoRe project

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In the EduCoRe project four pilot projects were planned, organised and implemented in Austrian, German, Italian and Slovenian medical rehabilitation centres. In Denmark, similar counselling and training offers already exist in rehabilitation centres. A special description about one of such vocational rehabilitation centre follows in chapter 4.6 after the presentation of the four pilots.

4.1 Cooperation with national rehabilitation centres

The pilots of the EduCoRe project have been carried out in medical rehabilitation centres in Austria, Germany, Italy and Slovenia. During this testing phase, 54 patients have been involved, whereby 19 dropped out due to different reasons such as return to work, family engagements, physical problems, lack of self esteem and distrust in the training.

The first contacts with the rehabilitation centres took place before the official start of the EduCoRe project, which was in December 2008. Since then, several meetings between the rehabilitation staff and the

partner organisations (and their trainers and counsellors) have been organised and held.

The selection of the patients who participated in the piloting courses was done by the staff of the rehabilitation centres. Therefore the EduCoRe consortium needed a close and well functioning communication and cooperation within the national rehabilitation centres. Organisation, communication and cooperation were some of the key factors leading to the success of the EduCoRe project.

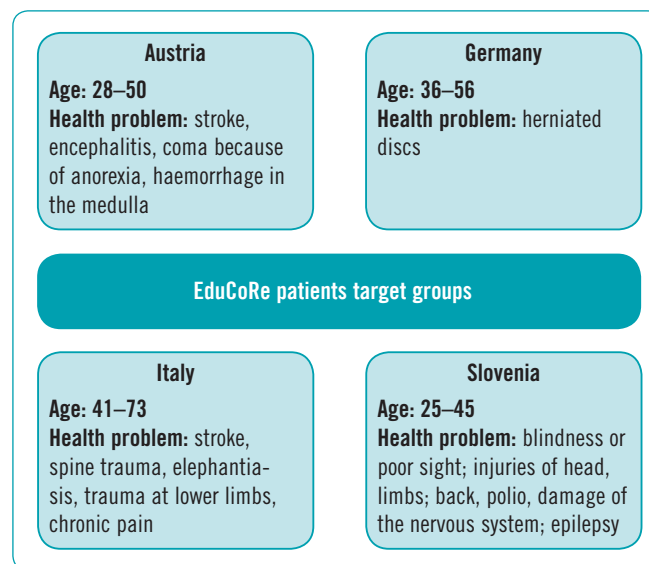


Fig. 15. EduCoRe patients target groups

Patients with the help of the staff of medical rehabilitation centres have to integrate the course and its topics into their rehabilitation path.

4.2 Patient target groups of the EduCoRe pilots

The patient target groups in Austria, Italy, Germany and Slovenia were diverse regarding age and health problems as demonstrated in the figure 15.

A detailed description of the different target groups and of the national pilots follows:

4.3 Four pilots conducted in rehabilitation centres in Austria, Germany, Italy and Slovenia

4.3.1 Austria

General information on the pilot course

Period of delivery	01/2010–05/2010
Number of patients engaged	8
Number of drop-outs	3
Number of counselling sessions delivered	60
Number of training sessions delivered (à 2 hours)	7
Staff from education provider involved in the piloting	one trainer, one counsellor

Fig. 16. Data of Austrian pilot

All eight patients of the pilot course have been day patients in different stations during the EduCoRe pilot phase. These persons were expected at the beginning of the counselling and training course

to find a new job, to gain experiences on the PC and also to find a training programme, a labour market and a way of integrating into the labour market.

4.3.1.1 Methodology to motivate and maintain the attention of the group

The patients' motivation was a result of the voluntary participation in the counselling and training offer. This ensured interest in the topic since the beginning. Furthermore, the regularity of the training sessions was an important motivator for the patients: each week the patients exchanged their experiences with people dealing with similar situations. The neutrality of the trainer was essential for the patients' exchange process. Out of the trainer's point of view, no additional methodologies were necessary for motivating the learners. Due to reasons unknown, the patients' motivation regarding the use of the online platform was very low. Although the trainer tried to interlink the face-to-face trainings with the content of the online platform, the use of the e-Learning offer was rather rare.

4.3.1.2 Interaction between group and trainer

The participating patients were very open minded, thus they were mainly interested in personal themes such as stress management strategies, worries or changes in one's environment. A disadvantage regarding the interaction between the learners and between the learners and the trainer was the small number of participants which made group work difficult.

4.3.1.3 Critical situation of the training course

The small group often hindered the proposed group works and the different therapy plans of the patients, which made it difficult to find a date for the training session.

4.3.1.4 Online learning part

The participants had different pre-knowledge of ICT: Some patients already had experiences with a computer; others didn't – for the

experienced, the access as well as the usability of the online platform was given, but not all patients had private access to the internet. Knowing this, the trainer organised a computer lab which the patients could use after each training session. In general, feedback from learners regarding the online platform was positive. The learners were encouraged to use the platform frequently by the trainer and the counsellor.



Fig. 17 and 18. Screenshots of the Austrian pilot course

4.3.2 Italy

Period of delivery	02/2010–05/2010
Number of patients engaged	15
Number of drop-outs	7
Number of counselling sessions delivered	48
Number of training sessions delivered	10
Staff from education provider involved in the piloting	two trainers

Fig. 19. Data of Italian pilot

Most patients who participated in the EduCoRe testing phase were day patients. Most of them were adults or elderly. The average age of the target group was about 54 years.

Most of the patients of the Italian pilot either were, due to the age, retired or were able to return to their former working position.

4.3.2.1 Methodology to motivate and maintain the attention of the group

The main element used to motivate the group was to make them aware that helping oneself can include helping others in similar situations. The group immediately started a conscious and sincere course with the aim of achieving self-motivation. All the members of the group changed their own habits and organized their every day life in order to attend the course. The attention of the entire group has always been very high, similar to their participation with meetings. A positive and cooperative climate was created and this allowed greater personal opening.

4.3.2.2 Interaction between group and trainer

The quantity and the quality of interaction amongst the group and between the group and the trainer were considerable. A continuous and orderly exchange of ideas, considerations and sensations

allowed a very constructive confrontation. The participants were very diverse in terms of personality and discussions tended to be very fruitful: other opinions were accepted, and different versions of a same theme presented.

4.3.2.3 Critical situation of the training course

The only critical point was the high engagement in terms of time for the patients. It was not easy for everyone to balance the course with their daily routine, due to the patients' occupation. For the same reason, most of the participants were not very interested in the job application module.

4.3.2.4 Online learning part

Most of the participants were not habitual PC and Internet users, some of them since they had never used a computer before and thus had no basic knowledge (such as using a mouse, how to open and close a document, how to write a text etc.). Due to the characteristics of the target group, some online sessions had to be carried out introducing the online platform (functions, usage, etc.). Through the help of the trainer and the more expert participants, all the members of the group understood well how to access the platform autonomously.



Fig. 20 and 21. Screenshots of the Italian pilot course

4.3.3 Germany

Period of delivery	02/2010–05/2010
Number of patients engaged	14
Number of drop-outs	5
Number of counselling sessions delivered	14
Number of training sessions delivered	10
Staff from education provider involved in the piloting	one trainer

Fig. 22. Data of the German pilot

The patients who participated in the German pilot course expected to have better future perspectives after finishing the EduCoRe pilot course.

4.3.3.1 Methodology to motivate and maintain the attention of the group

The trainer showed the participants video clips and podcasts in order to have a variety of media. As there was a general lack of concentration, the trainer used media in a lively manner. Another method of

maintaining the attention of the group was the discussion of the patients' own situations. The trainer carried out a lot of examples and role-play scenarios concerning the biographies of the participants. In addition, the trainer asked a lot of questions concerning their situation, well being, future perspectives, occupational alternatives, etc.

4.3.3.2 Interaction between group and trainer

The group was open both to the trainer and to the other group members. Most participants asked the trainer for advice and consultation concerning application questions, but also in the field of individual problems or difficulties. The participants tried to carry out all of the tasks the trainer gave them and only one showed some resistance. The quality of the interaction was very good. This is also stressed by the fact that at the end of the training a barbecue was planned in the allotment of one of the participants. There was a lot of exchange and a good atmosphere of mutual support and benevolence. Even though the group were very heterogenic and had a huge variety of educational and occupational backgrounds, their common illness and unclear future made them stick together.

4.3.3.3 Critical situation of the training course

The main critical situation did not depend on the training but on the general situation in Germany: Currently, the legal situation in the rehabilitation sector is constantly changing. Many new regulations led to the situation that it is no longer allowed for rehabilitation centres to bring together external trainers with the patients. During their stay in the rehabilitation centre, the patients were paid by the social pension fund, which gave the order that all rehabilitation centres have to communicate which kind of daily treatments and sessions the patients have. This treatment plan has to be accepted by the social pension fund before the rehabilitation starts. All additional lessons, trainings or treatments are forbidden and, in case of any disorder that might occur, the patients must pay by themselves. This relatively new legal situation turned out to have consequences on the project, since it was very difficult to find a German rehabilitation centre willing to give the German partner the possibility to get

into contact with patients. On the other hand it was difficult to find patients that were willing to join the training in their free time, as there was the risk of sanctions by the social pension fund if they were found out.

Other new regulation obliges all certified rehabilitation centres to employ at least one psychologist and one social worker. The consequence for the German partner was that they were not able to offer the consulting in all cases.

Among the participants, a lack of concentration was observed due to the fact that most of them were not used to being involved in a learning environment, as their experience with education ended a long time ago. But through the variety of tasks and short duration of the single training elements, the course went well.

4.3.3.4 Online learning part

The online platform was explained during the face-to-face meetings and patients took this opportunity to work with the modules whilst in the rehabilitation centre. According to their feedback, this was the most common usage they made of the e-Learning offer. They rarely went on the platform on their own and only one patient re-discovered his skills in working with a computer and stated that, thanks to the e-Learning offer, he would like to work more frequently with a computer in the future.



Fig. 23. Screenshot of the German pilot course

4.3.4 Slovenia

Period of delivery	02/2010–05/2010
Number of patients engaged	17
Number of drop-outs	4
Number of counselling sessions delivered	36
Number of training sessions delivered	20
Staff from education provider involved in the piloting	one trainer

Fig. 24. Data of the Slovenian pilot

Patients who took part in the Slovenian pilot project expected to gain knowledge about the national labour market, job opportunities and further education possibilities. Furthermore, the participants wanted to exchange their experiences with persons in similar situations.

4.3.4.1 Methodology to motivate and maintain the attention of the group

There was the active involvement of the participants in one of the two Slovenian pilot courses: discussion was especially valued very high.

4.3.4.2 Interaction between group and trainer

The trainer tried to make sure that all of the participants were involved. Hence, all, including the more silent ones participated actively in the discussions since the group and the trainer managed to create a relaxing atmosphere in which all patients openly expressed themselves. When patients felt the need they also announced their dissatisfaction regarding a topic, the learning process or the relationships in the group.

Some of the patients met once a week in addition to the training session on their own initiative. Patients supported each other with the online platform and motivated and encouraged each other towards further education.

4.3.4.3 Critical situation of the training course

In the second piloting group, several issues related to communication amongst the group arose: listening to each other; respecting the space each of them needed to express him/herself, inappropriate feedback that was perceived as insulting etc. In addition to this, the group was from time to time de-motivated because of the negative feedback they received from companies who rejected their applications. They had the feeling that there were too many obstacles within the existing legislation and that the society as a whole didn't believe they would ever get a job.

4.3.4.4 Online learning part

None of the participants in the Slovenian pilot project had any experience with e-Learning before. Some of them were therefore curious about it, especially those who had fairly good computer knowledge. Some of them needed face-to-face counselling in the beginning for initial motivation. A few patients were not interested in using the platform from the very beginning. Regarding the usability, patients (especially blind patients) were very glad they could use the platform without major difficulties.





Fig. 25 and 26. Screenshots of the Slovenian pilot course

4.4 Main achievements of the EduCoRe pilot courses in Austria, Germany, Italy and Slovenia

The experiences made in the *Austrian rehabilitation centre* have proved that the patients reflected on their new life situation in terms of possible ways to re-enter the labour market. All patients gained new perspectives in regard to their occupational future. The counselling part of the EduCoRe offer especially gave patients a feeling of positive support regarding their professional comeback. The trustful working atmosphere between the patients and the trainer/counsellor ensured space and time for open talks about the participants' situation, worries and aims.

Participants in *Germany* valued the fact of group support. Patients gained the knowledge that other people have also to deal with similar situations. The participants stated that they were happy that an external person was there with whom one's thoughts could be reflected. Most participants in the German pilot course had no concrete idea of what to expect from the course when they started it and

some were very frustrated, but nearly all knew at the end some possible professional alternatives. Also to become well prepared for the application processes (developing one's portfolio, increasing one's knowledge about the labour market, application strategies, etc.) was seen as very positive by the participants. The participants mentioned that they have less anxiety about the future and more confidence in their own potential, now that they have objectives for the future, not only in a professional direction but also in the private one. Some participants mentioned that their families noticed a positive change in their mood.

In *Italy*, the participants considerably increased their communication ability, their capacity for self criticism and (realistic) self observation. These Patients started to indulge in enjoyment and abandoned pettiness for their own situation and expressed their own qualities and strong points. All the participants of the Italian pilot course managed to use the online platform and to learn the basic notions in order to use the PC and Internet.

In *Slovenia*, the majority of the participants of the EduCoRe pilot course said that they were much more motivated for entering the job market after the course. As a result of the course the patients became much more self-motivated and proactive. This was also observed by the staff of the rehabilitation centre. The participants got the experience of e-Learning (which some of them pointed out as a very valuable experience) and for some, working with the computer and using e-mail was already an achievement. It must be noted that the dynamic of the group, their mutual support and encouragement was a great achievement in Slovenia.

4.5 Obstacles and challenges of the EduCoRe pilots defined in Austria, Germany, Italy and Slovenia

In *Austria*, the target group was quite inhomogeneous as some patients were overwhelmed by the training offer and others weren't. This made fluent work with the participants difficult. Furthermore,

the rehabilitation centre unfortunately did not send as many patients to the course as agreed on at the start of the project. The reason for this is unknown, only assumptions exist which are traced to the lack of communication and interaction between the Austrian partner institution and the Austrian rehabilitation centre. Due to the small group, the trainer was not able to initiate a group dynamic process and mainly single work, such as interviews (pair work) and discussions in pairs were used as methods.

Also, the experiences made in *Germany* showed specific problems in the interaction between the cooperating rehabilitation centres. Furthermore, currently changing regulations in the rehab sector in Germany combined with the fact that the project consortium was not very well educated in the field of rehabilitation led to a lot of questions. The training was only possible because of an experienced trainer who was in a position to adapt the curriculum in accordance with the specific needs of the target group and who had a lot of experience with heterogenic learner groups.

Criticisms which have emerged from the *Italian* experience are connected to the target groups' expectations and competences. All the members of the group had to reorganize their own daily life in order to manage to „fit“ the course into their schedule. As most of the participants of the Italian pilot were employed most of them were not interested in the application module. For further similar counselling and training services, the participants should be familiar with the counselling and training material: people who after their phase of medical rehabilitation want to re-enter the labour market in a new working environment.

Regarding the online platform, the greatest challenge was to convince the learning group of the quality of the blended learning methodology and to provide the patients with a minimum knowledge of ICT for using the EduCoRe platform.

In the *Slovenian* pilot course, participants criticized that the experience made in the labour market was for some of them rather

disillusioning – they were facing several rejections and found that the moment they pointed out they were handicapped (to a certain degree) the employer lost interest in them. Furthermore the patients didn't want to focus too much on their handicaps but wanted to move forward.

As mentioned above, the Danish partner did not conduct the pilot course as the other EduCoRe partners did, but got in contact with a rehabilitation centre that already provided vocational counselling to their patients. The following excursus describes the cooperation between the Århus Social and Health Care College and the centre for Brain damaged people and the consequences for the EduCoRe project:

4.6 Excursus: Vocational counselling and training for rehabilitation patients in Denmark

4.6.1 Centre for Rehabilitation of Brain Injury in Århus

The Danish partner of the EduCoRe project, the Århus Social and Health Care College got in contact with the Centre for Rehabilitation of Brain Injury in Århus in January 2008. During the first meeting, it turned out that the centre aims at the same idea as the EduCoRe project: guiding patients who have been through a disease or undergone an accident back to working and social life. Many of the issues that have been formulated as the ultimate aims of the project have already been thoroughly tested at the centre, and have been integrated in the daily practice. Furthermore, there is much awareness at the centre of *what* the patient (or client) does during his/her counselling, *when, how and why*.

Out of the total number of staff of 17 employees, 13 employees (including the director of the centre) carry out counselling concerning the return to the labour market as an integrated part of their work with clients. Only the centre's secretaries and the physiotherapist do not provide such counselling. The fact that the director of the centre

himself provided counselling also appears to have made a positive impression on the centre.

Due to these circumstances in Århus, the project consortium agreed that the Danish partner wouldn't pilot the EduCoRe counselling and training material in the centre but would discuss it with its employees in regard to getting professional feedback from persons who already work in this specific counselling and training context. The outcomes were taken into consideration during the phase of the material finalisation.

4.6.2 Situation for rehabilitation patients in Denmark

It is a statutory requirement that vocational/professional counselling *must be provided* at the Centre for Brain Damage according to LAB §32 (Act on active employment policy). The staff carries out work concerning the clarification of issues related to the labour market and job integration activities in relation to the clients.

In the Centre for Rehabilitation of Brain Injury in Århus, there are two different offers for patients:

4.6.2.1 The Intensive offer and the Flexible offer

In *The Intensive Offer* clients are enrolled for 6 months during which they are at the centre 4 days a week from 9.00 AM to 14.15 PM. These six months are succeeded by a 6–12 month follow-up, during which the client usually tests his/her abilities on the labour market through practical training. In *The Flexible Offer*, the clients are in 4½ months with two weekly exercise days at the centre. Simultaneously with training at the centre most of them are doing practical training 2–3 days a week at a working place. When the fourth month of enrolment is finished, there is a 7–8 months follow-up during which the centre remains in contact (counselling sessions, interviews, meetings etc.) in order to support the effort of returning to the labour market with maximum profit.

On average, the clients inflicted with brain injuries are hospitalized in the *Intensive offer* for 195 days, in the *Flexible offer* for 55 days.

Due to the light forms of brain injury, many of the clients have actually tested their capabilities returning to work, and they have experienced that it was harder than they expected, which is why they are seeking help.

Both offers at the centre – for all clients – include treatments, teaching concerning the brain and its functions, cognitive training, concentration training, emotional and social training, communication training, cooperation and problem solving, physical training, preparation for working life including the social code of practice in the work place and the options to obtain employment. Furthermore, patients receive psychological consultations (individual and group therapy), information about labour market and education, juridical matters and insurance, contact to future potential employers, organisation concerning traineeships and work tests and introductory visits to future potential employers.

After the stay at the centre, there is a follow-up period of up to 12 months, during which the client has the option of counselling at the centre and meetings to exchange experiences with his/her previous group along with his/her work practice. Also, in this period, the centre has contact with the employer with whom the client has his/her work test/traineeship.

At the centre each client has a contact person, who is responsible for the course and re-entry into the labour market of the client. This contact person manages the individual consultations and coordinates the cooperation with internal and external collaborators. Thus the contact person is also the person managing the organization of the client's re-entry into their professional life through traineeship/work test and the preparation for a possible flexible job. One staff member is the contact person for up to 7 clients.

4.6.3 The importance of qualified counselling in connection with rehabilitation

Almost all clients at the centre are very insecure about their situation and what consequences brain damage might have for them. The first task for the staff along with the client is to draw a realistic image of

the client's situation and to carry out work concerning how to learn to live with the situation they are in now. Some damages may be improved with training and practice but some damages can never be cured. In order to be able to move on, both in a private and professional capacity, a patient needs to detect new resources and to learn to cope with memory loss (also in his/her future life).

Therefore the counselling sessions, and the fact that they are conducted in a competent manner are extremely important. This means that counselling is not about giving good advices and recommendations. It is about setting the scope for the often painful, process of acknowledgment that the individual has to undergo. If the right basis for making professional and educational choices is not established, then a risk of making decisions that are not sustainable for the patients exists.

4.6.4 The complete human being in rehabilitation

While guiding a person undergoing rehabilitation back to working life, it is important not to have a narrow-minded view of this return, but to consider the overall life situation of the concerned person.

Sometimes, a person cannot engage in his/her interest and hobbies to the same extent as he/she did before. These persons might not participate in social activities with the same amount of joy and energy as before. This means that the counsellor has to be aware of the changes happening in relations to the patient's family, friends and people closest to them in their lives. Therefore, spouses are invited to some of the sessions, and arrangements are held for acquaintances, relatives, friends and colleagues of persons in rehabilitation to inform them about brain damage and the consequences for the affected person, as well as for their social environment.

4.6.5 Counselling in the Centre for Rehabilitation of Brain Injury

The counselling of the clients in rehabilitation consists of the following four elements:

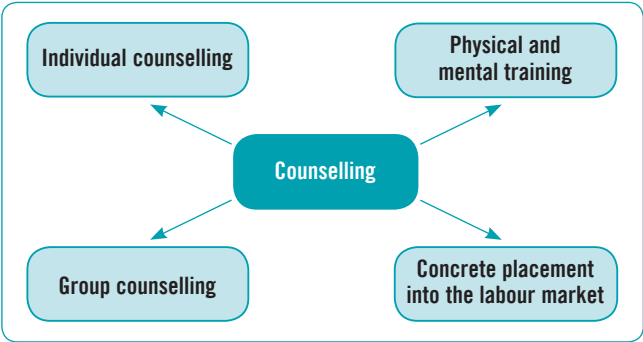


Fig. 27. Four elements of counselling

The following section summarizes these four elements of counselling:

4.6.5.1 Individual counselling

The individual counselling at the centre is composed of the five steps of counselling described in chapter 3.2.2. whereby the first step of the counselling is always to “unravel and clarify the situation” before models for solutions are considered. An insufficient description of a problem makes problem solving difficult or even impossible, and could imply that a “wrong” problem is solved.

An individual who has undergone an illness or an accident implying a new and changed condition regarding their health situation has an urgent need to clarify his/her new (life and work) situation. Strengths and weaknesses should be identified in the counselling process, as well as paths towards competences and the obtainment of qualifications which are crucial for the person's social and working future. When an acknowledgment and understanding of the individual's new situation has been obtained by the client, the counsellor works on getting the client to see and develop new perspectives and new angles in relation to his/her situation and what to do next in order to reach these new aims. Therefore an action plan is prepared and the concrete entering into the labour market can be initiated.

4.6.5.2 Group counselling

The group counselling takes place in the manner that a group of 6 to 9 people are sitting in a circle with the counsellor and each individual's situation, problems, fears, etc. are discussed. Everyone can talk about what is on his/her mind, whereby the dialogue is led and facilitated by the counsellor.

This element of the counselling process is important for patients as they recognise that they are not alone, that other persons have similar problems and difficulties to deal with and that a common understanding among the patients exists. The group counselling setting also gives time and place to give each other honest feedback about specific behaviour and observations; the group also functions as a training ground where the patients can practice talking about their situation.

Patients participating in the group counselling mentioned that they received something from the others of the group. They had regarded everything that had happened as a loss, but then suddenly they received something which helped provide energy and a desire to move on in life.

4.6.5.3 Physical and mental training

At the centre it is prioritized to provide training parallel to the individual counselling and group counselling. First the diseases that affect the participants and their body parts that have been damaged are taught. In this case, much of the training is about the brain, how it functions and what can happen to it in connection with an illness or accident.

The training contributes to promoting the understanding of one's health as well as knowledge about the effects and the consequences for the patient. Subjects related to financial compensation are taught, as well as possibilities about existing support schemes on the labour market, which are also relevant. Input regarding communication as well as problem and conflict solving are also given. All

of these themes equip the clients for difficult situations that might occur in future, both in private and in working life.

4.6.5.4 Return to the labour market: The practice of the Centre for Rehabilitation of Brain Injury

50 % of the patients return to their former work place, but not necessarily to their old occupational position. Since 1994 the centre has taken on the task of contacting employers in order to find a new working place, normally starting with a traineeship in cases where the clients cannot, or don't want to return to their old company. It is important not to start too early with the planning of the occupational comeback – first, the concerned person has to have a realistic image of him/her.

The success that the Centre for Rehabilitation of Brain Injury has in the reabsorbing of clients into the labour market is both connected to the method applied by the centre and also to the existing support schemes in the Danish society.

With the help of the centre's staff, patients find work back in the labour market: When a person who has undergone rehabilitation returns to working life, a meeting is always held at the working place in which the employer, the client and an employee from the centre participate. This takes place if the client is returning to his/her former work place (possibly in a new job function) or if he/she is starting in a new work place.

At the meeting, the representative from the Centre talks about how the disease affects the client and what its consequences could be for daily work. It is also discussed how the work could be planned to compensate for the shortcomings of the rehabilitating client. Accompanying the patient to his/her working place can support this person with providing a realistic image of him/herself. Furthermore, the type and extent of the work are discussed between the staff member of the rehabilitation centre and the future

employer and the patient. Opportunities such as Flexible job¹⁹ or Light job²⁰ are given in Denmark to ensure that many people have the chance to return to working life.

5. Evaluation of blended learning activities in rehabilitation centres, recommendations and critical points

Reinhard Bauer, Sabine Zauchner

The EduCoRe project was continuously accompanied by a formative evaluation approach. Therefore, in focussing on the quality of the EduCoRe product,²¹ the evaluation formatively assessed the development of the materials as well as the piloting of the services. It was to be expected that the preconditions in the different countries, taking part in the EduCoRe project, were quite heterogeneous with regard to the level of experience with educational training, counselling and/

19 Flexible jobs are attractive for persons who can't work fulltime and ensure occupation for those who would otherwise be receiving early retirement pension. Persons who have a part time flexible job receive the same wage as people fulltime employed on regular terms in the same type of job: The employer pays only for the hours the person is actually working and the municipality pays the difference to the fulltime salary. The working conditions such as speed, breaks, preparation of working environment, etc. are planned according to the person's needs. Preconditions for getting a flexible job: the persons have the right age, the person has to be less than 65 years, and the working capacity should permanently decrease. Furthermore all possibilities of replacing and training must be examined. Flexible jobs can be arranged with private and public employers.

20 If conditions for a Flexible job are not given due to bad health conditions or other reasons, people concerned can apply for sickness pension or for a so called Light job. Receiving a full or part time light job requires that the person is less than 65 years and is on disability retirement. Pay and work conditions are determined between the employee and the employer in cooperation with professional organizations.

21 The main product of the EduCoRe project is the KIT for rehabilitation counselling and training which consists of the EduCoRe Approach, a training curriculum and a booklet including materials for face-to-face training and e-Learning objects. Secondly an internet platform for e-counselling and e-Learning was developed.

After the client has started working, he/she is still attached to the centre for a period of time and is thus able to get help and support from the centre to tackle the first and maybe most difficult period.

or the implementation of blended learning in rehabilitation centres. Therefore a comprehensive evaluation strategy was chosen, which involved quantitative, as well in-depth qualitative methodology. Further, the development process was not only evaluated internally by the evaluation partner responsible but also by an external expert. By this it was assured, that the development of the project outcomes was continuously accompanied from the beginning to the end.

5.1 Evaluation strategy

The EduCoRe evaluation strategy contained the following main elements:

Internal evaluation of the draft kit and of the platform by the consortium members.

The aim of the internal evaluation was to assure continuous exchange of ideas and reflection on the project outcomes during the whole development process. This evaluation part was done internally by the project consortium, i.e. all members of the project team. Besides the collection of structured feedback, reflection groups with the project members were held.

Evaluation of the draft kit and the platform by an external evaluator.

An external expert was contracted with the evaluation of the draft kit. The main focus of the external evaluation was the contents of the materials developed as well as the general intention and structure of the EduCoRe project.

Evaluation of the pilots by the target groups, i.e. the final beneficiaries (rehabilitation patients), trainers/counsellors, the coordinators

of the pilots, and the representatives/contact persons from the rehabilitation centres.

For the evaluation of the pilots (see chapter 4) by the *rehabilitation patients*, questionnaires were provided after the termination of the course. The evaluation by the rehabilitation patients addressed their experiences with the pilots in general and secondly the impact, the pilot courses had for them personally. Evaluation by *trainers respectively the counsellors* was done by completing course diaries in order to get in-depth information of the process of the courses, successes and obstacles. Secondly, after the termination of the course, the trainers/counsellors were interviewed along a semi-structured interview guideline. One internal reflection group was held in the end of the piloting period with the consortium members in their roles as *coordinators of the pilots*. The *contact persons in the rehabilitation centres* were interviewed with regard to their experiences with the pilots along a semi-structured guideline.

5.2 Evaluation criteria

Evaluation criteria were developed with regard to the main project aims, i.e. to make rehabilitation patients thoroughly reflected career decisions, to identify the types of further education they need in their specific situation to improve their employability, and to develop their social and personal competencies necessary to put their professional and educational decisions into practice.

Evaluation criteria for the rehabilitation patients as well as for the trainers respectively counsellors besides the collection of demographic data contained the following main aspects:

Adequacy of learning contents and counselling activities	Personal benefit/impact of the course for the patients
Organisation/implementation mode of the course	Use of the e-Learning platform/evaluation of the technology
General impression/motivation	Recommendations for further courses

The reflection group with the coordinators of the pilots focused on the evaluation of educational aspects (focus on patients), implementation aspects (organisational prerequisites, cooperation with the rehabilitation centre) and technical aspects (platform, technical infrastructure in the rehabilitation centre) of the pilot implementations.

The main questions for the interviews with the contact persons in the rehabilitation centres were:

Positive/negative experiences with the collaboration with the project team?
Positive/negative impacts of the EduCoRe project for the rehabilitation centre?
Positive/negative impacts of the EduCoRe project for the rehabilitation patients?
What are the conditions to support sustainability for e-training and e-counselling in the rehabilitation centres?

5.3 Main evaluation results

5.3.1 Internal and external evaluation

Internal and external evaluation of the development process identified several critical points. The aims of the internal reflection groups and of giving structured feedback were the critical reflection of the development process, an assessment of the products developed and their suitability for the pilots as well as the identification of possible obstacles, challenges or To Dos with regard to the piloting phase.

The issues which were found to be important addressed the suitability of the face-to-face tasks and the e-Learning objects for the different target groups in the rehabilitation centres and secondly

the enhancement of the quality of the e-Learning parts of the Kit.²² Especially the lack of interactivity and the missing link of the face-to-face and the e-Learning parts needed to be addressed within the redesign of the EduCoRe products.

The challenges faced were also connected to the heterogeneity of target groups and national health systems. Further, the trainers for the pilots and the staff, which were intended to sustain the offers, highly differ in their competences of delivering training and counselling. This was also one main critique of the external evaluator and finally led to the re-adaptation of the target group for the EduCoRe products (see chapter 1.2.1): the materials were developed in order to support professional trainers and counsellors in their activities in rehabilitation centres and not – as initially planned – for (unspecific) staff of rehabilitation centres. They are provided with a tool box, a collection of materials, which needs to be adapted to different countries and the specific needs of the different target groups with regard to duration or the selection of suitable contents.

Further, it turned out to be important to clarify and define the terms “training” and especially “counselling” as understood in the EduCoRe project: Counselling does not refer to a psychotherapeutic or psychological process, but to job orientation and job application support. Further, the necessity to clearly state, in which stage of rehabilitation the patients need to be, in order to profit from the training and counselling offered, turned out to be important: The EduCoRe materials support patients in the phase of acceptance (see chapter 2.4.1), when they are open to accept his/her new life situation and are ready to receive job application training respectively re-orientation.

5.3.2 Evaluation of the pilots

For the *evaluation of the pilots* in total 32 patients (Germany: n=8; Austria: n=7, Slovenia: n=11; Italy: n=6; 17 females and 14 males;

22 E.g. Try to get a better feeling/idea of the target group the Kit is developed for; Think of tailor made tasks, think of suitability for the different rehabilitation patients; Put tasks “down to earth”, adapt them to the target group; Strengthen the link between face-to-face tasks and e-Learning objects; Design the Moodle platform in a manner, that the target group finds motivating and easy to use.

mean age: 41,48 with a range from 23 to 72 years) completed the questionnaires. Computer experience before the start of the course was equally distributed.²³ The stay in the rehabilitation centre before the EduCoRe course ranged from 2 to 240 weeks. The highest education completed was distributed as follows: 4 participants had a university degree, 5 high school degree, 11 secondary school, 6 vocational school, and 1 participant completed elementary school. The type of illness was very heterogeneous (for details see chapter 4).

Interviews were held with the trainers (N=4), counsellors (N=4) and the representatives of the rehabilitation centres (N=4). The main results of the piloting evaluation are presented as follows.

General impression/motivation

In general, the main part of the patients enjoyed taking part in the EduCoRe course (see Fig. 28). There was no patient who did not enjoy it. This was evaluated similarly by the trainers and counsellors, respectively the representatives of the rehabilitation centres. The positive evaluation of the course is also reflected by the answers to the question, if the patients would be interested in taking part in similar further trainings. More than two third of them would take part in similar offers.

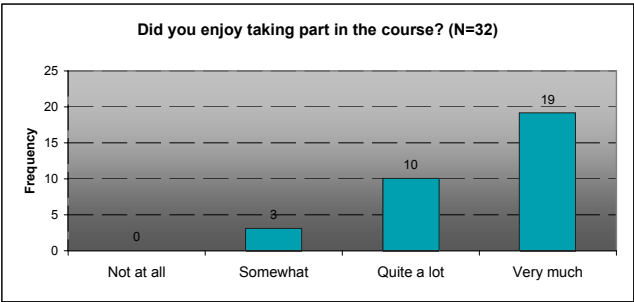


Fig. 28: Patients' experience of enjoyment with the EduCoRe training and counselling

23 11,4% of the patients had no experience, 22,9% had little experience, 34,3% were somewhat experienced and 14,3% had quite a lot of computer experience

The patients mainly appreciated the exchange of experience with other patients and the possibilities for communication and collaboration with others in the run of the course (n=15). The high quality of the counselling sessions was also mentioned by several rehabilitation patients (n=9). However, some of the patients did not appreciate the work with the computers (n=4), whereas computer skills were identified as a crucial prerequisite for the course by the trainers:

“Our problem was the lack of experience in computer skills of the patients. This may also have been the reason, that the e-Learning part was not so much appreciated by them”. (Counsellor Austria)

The patients appreciated the combination of face-to-face and e-Learning sessions and evaluated the support by the trainers and counsellors very positively. The face-to-face part and to a slightly

lower extent the e-Learning part themselves also were evaluated positively by the patients (see Fig. 29 and 30).

However, with exception of the Slovenian pilot, trainers were more negative with regard to the e-Learning part of the course: They found it to be too little interactive and did not appreciate the task-oriented didactic structure of the e-Learning objects. This led to considerable changes in the finalization of the e-Learning platform. Within the reflection groups with the coordinators of the pilots additionally the necessity for trainers to be sufficiently experienced in e-Learning was stated.

Adequacy of learning contents and counselling activities

As can be seen in Fig. 31 and 32 at least some of the contents and counselling activities offered were exactly what the patient needed. This result has to be regarded in the context of the heterogeneity of the target groups and accounts for the importance of a careful selection of the level of difficulty and an adaptation respectively a transfer of the contents to the needs of the specific target group, as stated by one of the trainers:

“It turned out that the materials were too sophisticated for my group. Therefore I often had to somehow ... translate ... the contents, to make them suitable to my participants”. (Trainer Germany)

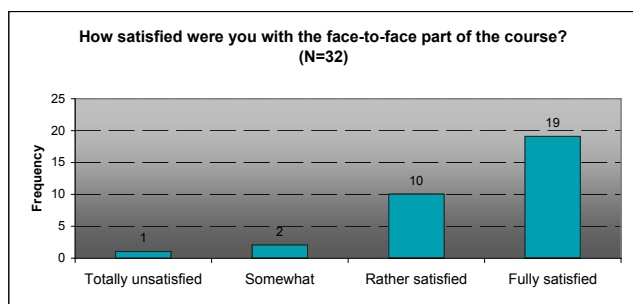


Fig. 29: Evaluation of the face-to-face part by the patients.

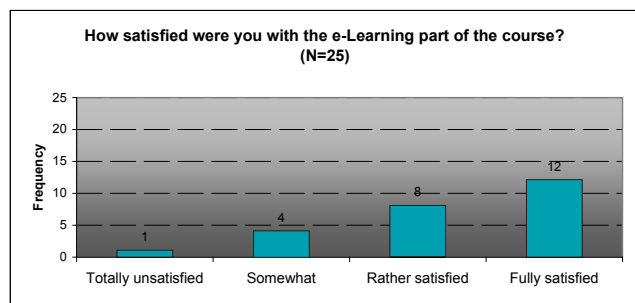


Fig. 30: Evaluation of the e-Learning part by the patients.

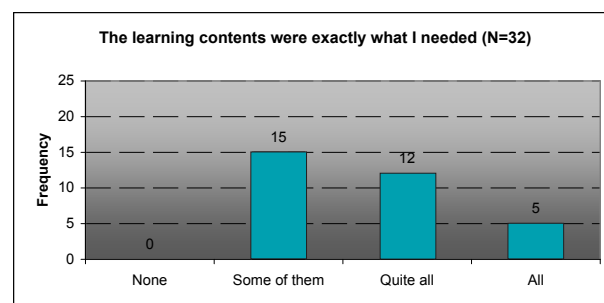


Fig. 31: Evaluation of the learning contents by the patients

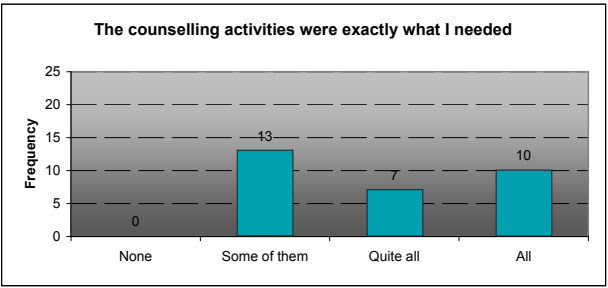


Fig. 32: Evaluation of the counselling activities by the patients

When asked, which contents were the most useful for the patients, the majority stated it were the job orientation and application parts.

Personal benefit/impact of the course for the patients

The personal impacts of the EduCoRe course for the patients are presented in Fig. 33 and 34. It must be stated that some of the patients did not profit from the course with regard to getting a clearer understanding of their professional career. This may be due to the fact that some of the patients did not fit to the EduCoRe target group, as some of them were preparing their retirement.

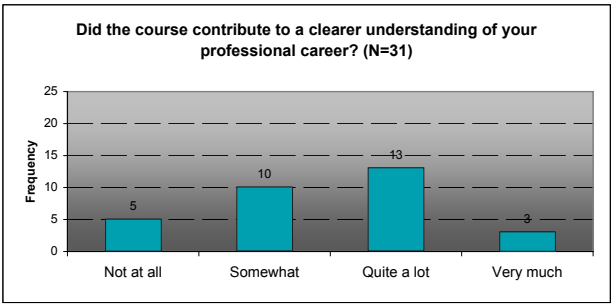


Fig. 33: Contribution of the EduCoRe course to a clearer understanding of the patients' professional career

When asked to which respect the course contributed to the development of personal competences, more than 2/3 of the patients realized

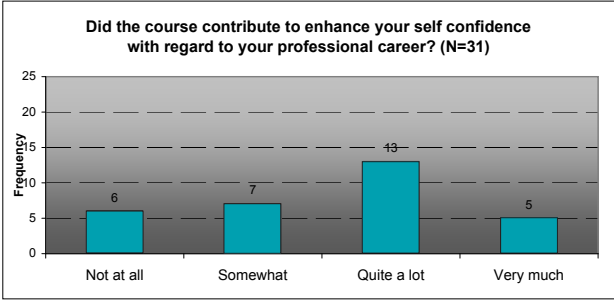


Fig. 34: Contribution of the EduCoRe course to the enhancement of self confidence with regard to the patients' professional career

changes, such as enhancement of self-esteem in general, positive thinking, better coping with problems, improvement of memory, improvement of computer skills, or improvement of communication skills.

These changes were also noticed by the trainers and counsellors and even by the representatives of the rehabilitation centres:

"Though not everybody found future perspectives, the feedback of the patients was very positive as they individually were able to improve competences" (Trainer Germany)

Organisation/implementation mode of the course

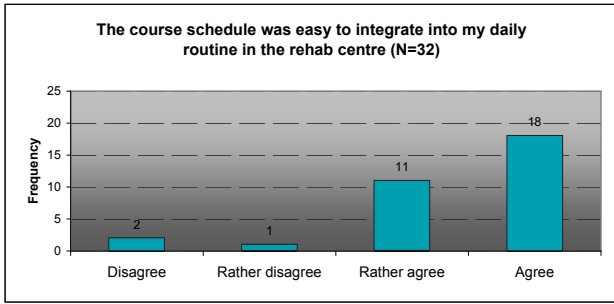


Fig. 35: Contribution of the EduCoRe course to the enhancement of self confidence with regard to the patients' professional career

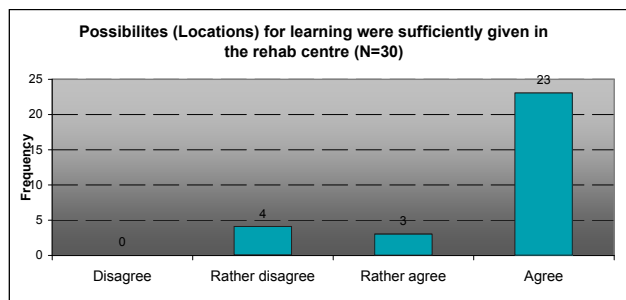


Fig. 36: Contribution of the EduCoRe course to the enhancement of self confidence with regard to the patients' professional career

The organisation, respectively the implementation of the EduCoRe offers in the rehabilitation centres, was seen very positively by the patients (see Fig. 35 and 36). The course schedule was easy to integrate into the daily routine of the patients and also possibilities for learning were sufficiently given in the rehabilitation centres.

However from the reflection group with the coordinators of the pilots, we know that the support of the rehabilitation centre as well as focussed promotion of the offers (e.g. information sessions with the patients) are critical factors for success.

Use of the e-Learning platform/evaluation of the technology

The learning management system Moodle was used to implement the e-Learning parts of the EduCoRe course. 2/3 of the rehabilitation

patients agreed on the fact that the availability and stability of the platform was sufficiently given. For some patients the use was too difficult, whereas sufficient support was given for almost all patients who participated in the course. Further, sufficiently access to computers or notebooks for almost all participants was provided.

The trainers – irrespective the already mentioned lack of interactivity and the missing link between the e-Learning objects and the face-to-face trainings – were sufficiently content with the stability, availability and navigation of the platform.

In sum, from the evaluation of the pilots it can be concluded that the EduCoRe training and counselling offers are valuable tools in order to support the aims of making rehabilitation patients thoroughly reflected career decisions, to identify the types of further education they need in their specific situation to improve their employability, and to develop their social and personal competencies necessary to put their professional and educational decisions into practice.

The EduCoRe materials provide experienced trainers and/or counsellors with a tool box of materials, they can adaptively use in job-orientation training and counselling for the specific target groups – patients of medical rehabilitation centres. The e-Learning elements can be used in order to enhance the face-to-face sessions and in their final version are well suited for didactically based blended learning scenarios.



Patients who have physical deficiencies after an accident or illness spend several weeks or months in a medical rehabilitation centre after leaving hospital. There they receive long-term treatment which aims at removing or at least minimising their physical impairments and thus allows them to re-enter the labour market and normal life.

But rehabilitation has not only a medical aspect: In many cases these patients need to undergo considerable re-orientation with regard to their career or (further) education. Many rehabilitation patients are forced to change occupation and/or need to identify appropriate lifelong learning offers which allow them to change their career. Others, particularly older patients who make up a large proportion of rehabilitation patients, take the time-off from their ordinary lives as an opportunity to think about new learning activities which would be beneficial for their personal development.

These needs pose a challenge to the concept of lifelong counselling and lifelong learning policies. People in rehabilitation centres need tailor-made educational and career counselling, along with strengthening personal skills which enable them to cope with their precarious life situation.