Social Assistance Academic Collection

MULTICULTURALISM AND SOCIAL ASSISTANCE

COORDINATOR:
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PRESA UNIVERSITARĂ CLUJEANĂ

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SOCIAL ASSISTANCE ACADEMIC COLLECTION

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in alphabetic order:

Foreword

This is the first volume of the *Social Assistance Academic Collection*, coordinated by professor Mihaela Gavrilă-Ardelean, PhD.

The scientific approach started from the need to include in a university collection theoretical and practical aspects in the field of social work. Titled *Multiculturalism and Social Assistance*, this first volume is published in English so that international specialists can find a common language in social work.

The volume brings together under the term "multiculturalism" specialists in the social work area, from practitioners to university professors who come from different countries and cultures, into a unitary whole of the common culture of social assistance, which deserves international recognition. This volume aims to bring together, through the heterogeneous composition of the authors' national culture, a universally valid professional heritage, that of social work, with the matching definition of serving the needs of others, as a social culture shared beyond geographical borders. Extrapolating the theory of multiculturalism, as advocated by its founder, Will Kymlicka (1995), shows that a common international culture in social work requires positive adaptation of national practices in the light of group-differentiated rights.

If the culture of assisting people in need will emerge as a red thread from the *Social Assistance Academic Collection*, then the collection has fulfilled its purpose. People can become beneficiaries by subscribing to a vulnerable group at any life stage.

To achieve this objective, we invited authors working in social assistance as practicing social workers, graduates of a profile faculty,

alongside trainers, theoreticians, academicians, and founders of higher education in social work to share their rich professional and academic experience.

Have a fruitful reading towards the assistance of beneficiaries, in the academic module of social work.

Coordinator

SECTION I.

Social Assistance in Different Cultural Contexts

Cultural competence in transnational migration: *A social work perspective*

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Abstract: In the current era, globalization as a cultural phenomenon is principally marked by the expansion of transnational migration and identities. Transnational migration, coupled with transnational identities, encompasses a considerable population of migrants who may encounter situations of pluricultural, bicultural, transcultural, intercultural, multicultural, cross-cultural or polycultural nature. Within the realm of social work practice, the concept of cross-culturalism or culturality stands out as particularly demanding, given that it necessitates cultural engagement between two diverse groups – namely the social worker and the migrant client. Consequently, regulatory bodies and professional associations in social work have defined criteria for cultural proficiency in the practice of social work, several of which are directly related to the comprehension of cross-cultural dynamics. These standards emphasize the ongoing development of cross-cultural insights (including aspects like artistic expressions, family structures, historical context, traditions, and major client group values) and the enhancement of methodologies, skills, and methods that demonstrate social workers' understanding of the role of

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culture in the practice of providing assistance. This paper elaborates on the essential standards for achieving cultural competence in cross-cultural understanding.

Keywords: cultural competence, cross-culturality, understanding, social work.

1. Introduction

Globalisation, in its role as a cultural process, has given rise to various global trends, such as the expansion of global consumption cultures, increased flow of media and information, growth in tourism, and the emergence of transnational migration and identities (Haidar, 2017). Specifically, the phenomenon of transnational migration and identities has become more prominent due to recent social events, such as the crisis in Afghanistan.

Being a transnational migrant / refugee and having one's own transnational identity can place individuals in a wide range of situations of culturalism, understood, in social sciences, as "a theoretical approach emphasizing the significance of culture, especially in determining individual behaviour and the way in which society functions" (Lexico, n.p.). Scientific literature promotes today terms such as culturality, culturation, biculturalism, biculturation, cross-culturalism, cross-culturality, interculturality, multiculturalism, pluriculturalism, polyculturalism, transculturalism or transculturation.

In dealing with migrants as a social worker, it is paramount to distinguish between these types of situations if one wants to find the best solutions for the cases they have to manage: the migrant and the social worker may find themselves in the same type of situation, or they may find themselves in one case of the dichotomies below (Iosim, et al., 2022). Thus, Rață (2013) presents the following dichotomic situations referring to culturalism:

❖ **Biculturalism or biculturation** (Gibson, 1984) - from 'bicultural' and they refer to 'having or combining the cultural attitudes and customs of two nations, peoples, or ethnic groups' – Lexico, n.p.) Biculturalism 'can occur in both bi- and multi-cultural societies' (Chen, Benet-Martínez & Bond, 2008, n.p.), and 'it is the first step to multiculturalism'. In this case, the migrant is in a bicultural situation since, step by step, he/she embraces the cultural attitudes and customs of the adopting nation, people, or ethnic group.

❖ **Cross-culturalism or cross-culturality** - from 'cross-cultural' and the terms refer to 'relating to different cultures or comparison between them' – Lexico, n.p.). These terms are synonymous with trans-culturalism or transculturation (Lexico, n.p.), and they are defined as 'the discourse concerning cultural interactivity' (Wikipedia). Both the migrant and the social worker can be in this type of situation since they interact with each other.

❖ **Interculturality -** from 'intercultural' and it refers to 'taking place between cultures, or derived from different cultures' – Lexico, n.p.). Interculturality is defined as 'the encounter between hegemonic [macro cultures such as European, East Asian, or Latin American – Gullestrup, 2001] and non-dominant cultures as well as frictions, overlapping, interdependencies, potentials for conflict and mutual interference caused by this' Interculturality or interculturalism can be defined also as 'a government policy regarding the relationship between a cultural majority and cultural minorities, which emphasizes integration by exchange and interaction' – Legal Dictionary (n.p.). Here, the role of the social worker is to try and prevent any frictions, interdependencies, overlapping, or potentials for conflict and mutual interference in his/her interactions with the migrant.

❖ **Multiculturalism:** It signifies the association or presence of several cultural/ethnic groups within a society (Lexico). Defined as the acknowledgment of special differences in cultures, races, and ethnicities, especially among minority groups within a dominant political culture (Encyclopedia Britannica), the social worker's role is to recognize the unique

cultural, ethnic, and racial variations of the migrant as part of a minority group.

❖ **Pluriculturalism:** Deriving from 'pluricultural,' this term pertains to a society or region that consists of several distinct cultural groups (Lexico). Pluriculturalism represents an approach to understanding oneself and others as complex, multifaceted beings acting from the perspective of multiple identifications (Wikipedia). Here, the social worker's responsibility is to assist the migrant in recognizing their equal importance within the society, nation, or ethnic group that has embraced them.

❖ **Polyculturalism:** This concept is defined as involving or consisting of various well-integrated cultural or ethnic groups, reflecting or embodying multiple cultural or ethnic influences (Lexico). Polyculturalism refers to the belief that distinct racial and ethnic groups engage with, shape, and are interlinked with one another (Rosenthal et al., 2019). In this context, both the social worker and the migrant recognize their mutual interaction, influence, and connection.

❖ **Transculturalism or Transculturation:** It is defined as involving more than one culture, or as being cross-cultural (Lexico). Tansculturalism is understood as a simultaneous two-phase synthesis. One phase entails the deculturalization of the past, mingled with the present, and the other represents the meeting and blending of various peoples and cultures. It emphasizes social multiculturalism and seeing oneself in others (Cuccioletta, 2002), as well as the fusion of political aesthetics with cultural civics (Lewis, 2002). In this scenario, the migrant undergoes a process of re-culturalization.

Three of the most important terms are: multi-culturalism, inter-culturalism and cross-culturalism. The differences between these three situations can be suggested by a graphic representation of multi-cultural, inter-cultural and cross-cultural communication as suggested by Schriefer (2018) (Figure 1).

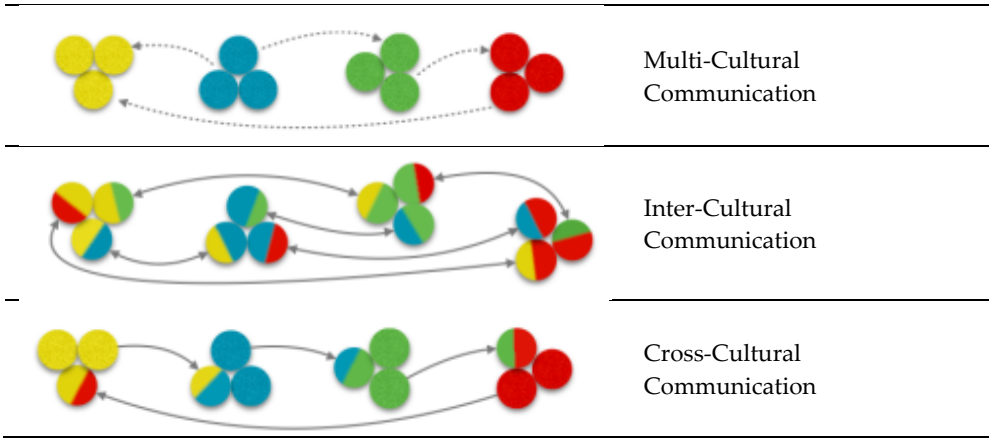

Figure 1. Multi-cultural, inter-cultural and cross-cultural communication (adapted from Schriefer, 2018)

The perspective of culturalisms, culturalities, and culturations indicates how the roles of the two actors under scrutiny here – the social worker and the migrant – change from one situation to another. Thus, the migrant goes from biculturalism / biculturation to transculturalism / transculturation through cross-culturalism / cross-culturality and polyculturalism, while the social worker goes from cross-culturalism / cross-culturality to polyculturalism through interculturality, multiculturalism, and pluriculturalism – with a proactive role in the last three types of situations. The two actors play comparative roles from only two perspectives – cross-culturalism / cross-culturality and polyculturalism – and that both these perspectives, together with interculturality, involve cultural interaction. The necessity for cultural interactions hinges on the cultural competence of social workers. This refers to their capacity to effectively engage with individuals from differing cultures to their own. Such competence is especially informed by an understanding and recognition of cultural distinctions (Dictionary.com). Cultural competence, however, is merely a single phase in the continuum of cultural (in)competence. This continuum encompasses stages such as "cultural destructiveness", "cultural incapacity", "cultural blindness", "cultural pre-competence", "cultural competence", and "cultural proficiency" (Cross et al., 1989; Rice, 2008).

2. Cultural Competence in Social Work

CSWE (2008, cited in Kohli, Huber & Faul, 2010, p. 257) outlines cultural competence as the proficiency of professionals to operate effectively with people from varied cultural backgrounds. These backgrounds encompass aspects such as age, race, religion, culture, gender, sexual orientation, class, physical or mental ability, ethnicity, and national origin. In the context of social work, Sue, Arredondo, and McDavis (1992) posit that cross-cultural understanding necessitates three specific cross-cultural competencies.

 beliefs and attitudes about ethnic and racial minorities, the development of a positive orientation toward multiculturalism, the need to check biases and stereotypes. Social workers' values and biases may hinder effective cross-cultural counselling.

 knowledge is specific to the cultural groups he / she works with, understanding of his / her own worldview, understanding of socio-political influence).

 skills which refer to strategies or intervention techniques.

In the realm of social work practice, cross-culturalism/cross-culturality, alongside interculturality and polyculturalism, presents one of the greatest challenges. This is due to the cultural interactivity required between two distinct individuals—the social worker and the migrant client. As a response to this complexity, social work regulatory bodies and professional associations such as NASW (2001, 2007), CSWE (2015), NLASW (2016), among others, have defined ten "standards for cultural competence in social work practice".

3. Cross-Cultural Knowledge

The standard of Cross-Cultural Knowledge in social work refers to an ongoing endeavor to attain and cultivate an in-depth comprehension of various client groups' artistic expressions, family systems, history, traditions, and values (Sue, Arredondo & McDavis, 1992; NASW, 2001, 2007;

Kee, 2014; CSWE, 2015; NLASW, 2016). This rich understanding enables social workers to provide effective and culturally-sensitive care.

From the clients' perspective, the following domains are essential for social workers to explore and appreciate:

Cultural Influence: An understanding of how culture shapes individuals' attitudes, behavior, and values.

Policy Impact: Insight into how social service policies directly affect client groups.

Power Dynamics: Awareness of how power relationships within agencies, communities, or institutions influence clients (Colistra & Brown-Rice, 2011; Kee, 2014).

Provider Collaboration: Knowledge about specific providers that work in tandem with clients.

Cultural Spectrum: A grasp of clients' cognitive skills, historical experiences, adjustment styles, oppression experiences, learning approaches, resettlement patterns, socio-economic backgrounds, specific cultural customs, and worldviews (Gavrilă-Ardelean, 2016).

Resource Utilization: Familiarity with resources, such as agencies, informal helping networks, and research that can support client needs.

Communication Patterns: An understanding of clients' communication styles, including coherence, indirectness, pacing, and listenership (Tannen, 1984).

Service Delivery: Insight into the preferred ways clients wish to receive care and services.

Professional Values: Awareness of potential conflicts between professional values and client needs and strategies for resolution (Anand, 2014).

Wellness and Illness Beliefs: Understanding clients' perspectives on what constitutes wellness or illness and their help-seeking behaviors (Ashkinazy, 2017).

Adaptive Knowledge: Knowledge of the cultural, political, and social systems in the adoptive country, including barriers preventing diverse group members from using services.

Meanwhile, social workers themselves need to embody the following qualities:

Client-Centered Approach: Willingness to ask clients about their preferences and comfort levels in discussions.

Cultural Comfort: Ability to discuss cultural differences without discomfort.

Theoretical Familiarity: Understanding the limitations and strengths of current theories, processes, and practice models relevant to diverse clients' needs.

Critical Inquiry: Mastery of the skill of asking pertinent questions that guide care.

In summation, Cross-Cultural Knowledge is not merely a static standard but a dynamic practice, an ongoing pursuit that necessitates a profound, nuanced appreciation of the cultural fabric that shapes individuals' lives. Through a holistic understanding of these multifaceted dimensions, social workers can provide empathetic and effective support, tailored to the unique cultural realities of each client.

4. Cross-Cultural Skills

This standard pertains to employing suitable cross-cultural means that reflect the social workers' recognition of culture's role when helping people. This standard applies exclusively to social workers who must possess specific qualities and skills (Sue, Arredondo & McDavis, 1992; NASW, 2001, 2007; CSWE, 2015; NLASW, 2016).

4.1. Qualities Social Workers Should Have

Social workers, including agency administrators and direct practitioners, should:

Bias Awareness: Be conscious of stereotypes/biases and the way they may interact with the needs of various clients.

Flexible Response: Capable of adapting to various possible solutions.

Commitment to Equality: Dedicate themselves to reducing ageism, homophobia, poverty, racism, and sexism.

Openness to Differences: Be open to differences among people, encompassing aspects like masculinity and femininity, individualism and collectivism, power distance, and uncertainty distance (Anand, 2014; Kee, 2014).

Warmth and Willingness to Learn: Exhibit warmth and a willingness to work with clients from varying backgrounds.

4.2. Skills Social Workers Should Cultivate

Social workers should:

Cultural Assessment: Assess the meaning of culture for individuals or groups.

Comprehensive Evaluation: Conduct thorough assessments, recognizing cultural norms and behaviors as strengths.

Peer Consultation: Consult with colleagues for feedback and performance monitoring.

Advocacy and Empowerment: Demonstrate skills in client advocacy and empowerment.

Open Discussion Encouragement: Encourage open dialogue about differences.

Cultural Learning: Establish methods for learning about client cultures.

Technique Evaluation: Assess the validity/applicability of new knowledge, techniques, or research.

Communication Skills: Generate a broad range of verbal and nonverbal communication skills, responding to clients' communication styles (Tannen, 1984; Tracy & Robins, 2008; Samman, 2009; Tiechuan, 2016; Menaka, 2018).

Professional Style Analysis: Identify features of their professional style that impact culturally competent practice.

Intervention Integration: Integrate culturally-competent assessments into culturally appropriate intervention plans.

Client Involvement: Engage clients and respect their choices in goal development.

Language Sensitivity: Master interviewing techniques that recognize language's role in a client's culture.

Combatting Discrimination: Recognize and fight against various "-isms," stereotypes, and myths.

Response to Biased Cues: Respond to culturally-biased cues effectively (Rață, 2014; Mai, 2015).

Technique Selection: Select and develop methods that resonate with clients' cultural experiences.

Agency Interaction Understanding: Understand how the agency, community, client, and cultural systems interact.

Natural Support System Utilization: Utilize clients' natural support systems, such as families, spiritual leaders, and community resources, in problem-solving.

Diverse Collaboration: Work with a wide variety of people, regardless of cultural similarities or differences.

These qualities and skills together contribute to social workers' ability to provide effective and empathetic cross-cultural care, reflecting an in-depth understanding of the complex interplay between culture and individual experience.

4. Cross-Cultural Leadership

Refers to the ability to communicate various information about diverse client groups to professionals. Social workers must possess skills such as acceptance and tolerance, cultural competence, multicultural leadership, sensitivity to diversity, and tolerance of ambiguity to advocate for clients and empower diverse populations (NASW, 2001, 2007; CSWE, 2015; NLASW, 2016).

5. Cross-Cultural Understanding In Social Work

Dean (2001, p. 623) asserts that the notion of 'cross-cultural competence' is fundamentally flawed, labeling it as a 'myth.' The underlying rationale is that true competence in another's culture is unattainable, given that culture is a dynamic and complex entity, individually and socially constructed, constantly evolving, and embedded in language. This assertion raises questions about whether cross-cultural understanding itself might also be a myth, a proposition that is not necessarily valid. Indeed, specific cultural misunderstandings, such as those linked to body language interpretation (including eye contact, facial expressions, gestures, movement, and posture), conversational norms (such as direct/indirect information, rituals, taboo topics, and turn-taking patterns), spatial interpretations (like distance, personal space, and territoriality), and the conceptualization of time (including punctuality and the organization of time), can be mitigated or prevented through targeted learning and awareness (Fries, 2002; Samman, 2009; Gopal, 2011).

The field of cross-cultural understanding in social work certainly encompasses more intricate aspects and can be challenging to navigate. Almost two decades ago, Gray and Allegritty (2003, p. 3) proposed a nuanced approach to this complexity, suggesting that the discipline of social work should strive towards what they termed 'culturally sensitive social work.' This concept acknowledges the inherent difficulties in cross-cultural practice and emphasizes a respectful and empathetic engagement with the diverse cultural backgrounds of clients.

6. Conclusions

Social work represents a field with many challenges which refer to various cultural interactions. Social work often deals with situations which refer to culturalism, culturation or culturality.

The phenomenon of transnational migration has created various situations that include culturalism, culturality, and culturation. In this context social workers have opportunities for cross-culturalism and cross-culturality, which refer to interactions between the migrant and the social worker. Social workers who are involved in activities characterized by cross-culturalism and cross-culturality must have a high cultural competence such as leadership skill or knowledge.

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From the Institutionalization to Interventions in Liquid Fields
Notes on Social Work in Greece

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Abstract: This chapter explores social work in Greece, with a focus on its practice within dynamic social environments. It argues that the institutionalization of social work in Greece has primarily involved two key elements: (a) the development of specialized educational programs, particularly at the university level, and (b) the professional enhancement of the field. These efforts have led to the establishment of a robust professional identity. However, recent changes in state social and health policies have raised concerns regarding the clear delineation of professional roles, including those within social work. From this perspective, this chapter examines three pertinent areas in Greece: (a) the domain of addiction, (b) the field of mental health, and (c) the provision of flexible social services by local authorities. These areas shed light on the challenges faced by social work practitioners in light of evolving societal and policy landscapes.

1. Introduction

According to internationally recognized definitions, Social Work encompasses both an applied profession and an academic discipline. It entails promoting social cohesion, as well as the empowerment and emancipation of individuals. Fundamental principles such as social justice,

human rights, collective responsibility, and respect for diversity are considered central to the practice of social work. This multidimensional approach combines political and practical elements with intellectual foundations derived from specialized theories, social sciences, humanities, and local contextual knowledge. Therefore, it is crucial to consistently explore and comprehend the local, regional, or state-specific variations in the organization and theoretical underpinnings of social work practice. By doing so, a comprehensive understanding of social work can be achieved, acknowledging the diverse perspectives and methodologies influenced by the unique characteristics of different localities.

From this perspective, the objective of this chapter is to examine key aspects of social work in Greece. It begins by providing a concise overview of its institutionalization as a profession and an applied science. This historical context sets the stage for an important question: What is the current state of social work as it evolves within fluid social environments, where the professional and scientific identity of social workers is not well-defined and delineated?

Fluid social environments, as defined here, refer to the intervention contexts of Social Work that are increasingly prevalent in the era of fluid modernity (Bauman, 2006). In this period, characterized by the prioritization of risk management in social policy (Beck, 2001), social workers are confronted with a social human condition marked by globalization, eroded democracy, and pervasive fear of the unknown. In such a context, where fixed identities and semantic frameworks are elusive, social workers are not only tasked with addressing social issues but also with reshaping their own professional identity and critically reflecting upon the nature of their interventions. During the age of fluid modernity, as described by Bauman (2005), the theoretical and political dimensions of social work intervention have become increasingly indistinct and ambiguous, reflecting the broader societal uncertainties of this period.

2. Institutionalization of Social Work in Greece

The emergence of initiatives resembling social work in Greece, similar to other economically developed nations, can be attributed to the need for addressing social issues resulting from industrialization, as well as local challenges. One of the earliest and most significant organizations with a social work orientation in Greece was the Christian Youth Union (XEN), established in 1923, which continues to operate as an NGO. The international counterpart to XEN, the World YWCA, was founded 20 years earlier in 1894 and XEN remains an active member of this organization. The pressing survival needs arising from the Greek-Turkish wars were a key driving force behind the development of social work in Greece during that time.

The establishment of the first school for social worker training in Greece can be traced back to 1937. However, it wasn't until 1959 that social work received legal recognition (Dedoussi et al., 2004, p. 259). Presently, social work in Greece is offered as a four-year university program and is taught in four Social Work Departments located throughout the country. Additionally, there are various specializations available at the postgraduate level. The history of these schools is relatively recent, representing an evolution from earlier, more practical-oriented social work programs.

The first school for social worker training in Greece was established in 1937. However, it wasn't until 1959 that social work gained legal recognition (Dedoussi et al., 2004, p. 259). In present-day Greece, social work is a four-year university program offered in four Social Work Departments across the country. There are also several specializations available at the postgraduate level. These schools represent a relatively recent development, evolving from earlier, more practically-oriented social work institutions.

The separation and differentiation of social work education occurred primarily in the 1980s with the establishment of Technological Educational Institutions (TEI), later renamed ATEI in 2001. Notably, in 2019, all relevant departments were upgraded to Higher Education Institutions as part of the overall abolition of TEIs in Greece, signaling a recent transformation in the educational landscape of social work.

Social work distinguishes itself from other social sciences, such as sociology, both in terms of its applied nature and the ongoing specialization within social sciences during the early 20th century. While social work shares theories, analytical tools, and social research methods with these disciplines, it diverges from them due to its interventionist orientation, which focuses on resolving social problems and meeting social needs to achieve "social prosperity" (Asimopoulos and Teloni, 2017; Ioakimidis and Teloni, 2013). Social work is closely intertwined with political action in terms of its implementation.

Importantly, in contrast to related fields like sociology or psychology, the profession of social work has gained substantial recognition and establishment in recent decades, corresponding to the advancements in education. Social workers have emerged as a potent professional group.

This has led to a strategic focus of social work on mediation between individuals, individuals and institutions, and various entities. The profession has also witnessed clear legal delimitations. However, the deepening of social differentiation poses challenges to this delimitation. Therefore, the following examples are presented to illustrate these developments and the resulting challenges to the professional identity of social workers.

3. “Going to” Again and Again: Liquid Social Work

The recent evolution, leading to the proliferation of fluid environments in which social workers operate, has rendered the concept of social work an "contested concept" (Mackay and Zufferey, 2015). Furthermore, the nature of the psychosocial interventions that social workers are required to perform in these "intermediate environments" aims to renegotiate individual identities, ultimately seeking to redefine the fundamental values of life within a framework of self-reflection (Alexias, Tzanakis, and Savvakis, 2015; Tzanakis, Savvakis, and Alexias, 2016).

In the context of fluid modernity, as described by Bauman, close collaboration with other professions has led to broader changes in the

organization and value framework of social policies, resulting in the multiplication of intermediate fields of intervention. However, these changes do not stem solely from internal transformations within the profession of social work. Instead, networks tend to replace rigid bureaucratic structures in these fields (Teloni, 2011).

The emphasis on professional characteristics is diminished in favor of individual responsibility. Increasingly, social workers find employment in diverse welfare settings, requiring not only specialized education but also multidimensional individual capacities for offering assistance and collaboration (Hall et al., 2000). In the following sections, we will explore three examples of social intervention in Greece in which social workers play a pivotal role.

3.1. Social work in mobile multidisciplinary units: the "help at home" program

While social street work is not widely practiced in Greece and is primarily developed in major cities in the western part of the country, there is a well-established program that operates within fluid environments called the "Help at Home" program. This program primarily targets the elderly who are not fully independent and individuals with mobility impairments and specific challenges. Priority is given to those who live alone, lack sufficient family support, or have limited income that prevents them from accessing necessary services to improve their quality of life. The program has gained wide acceptance, benefiting thousands of seniors and people with disabilities (Skaperdas et al., 2010).

The "Help at Home" program operates through small mobile units typically comprised of three or four professionals, often including a social worker who assumes a key role. The team consists of a primary care nurse, an assistant, and in some cases, a driver. The composition of the team reflects the program's diverse interventions, which encompass counseling, psychosocial support, basic medical and nursing care, assistance with daily living needs, and support in navigating private and public services.

This program upholds values of independent living and individual dignity, acknowledging the changing dynamics of family relationships that have become less strong and binding compared to the past, leading to a rise in vulnerable and isolated individuals. It is estimated that a total of 4,500 professionals from various specialties are employed in this program, providing services free of charge to over 120,000 seniors and people with disabilities.

Operating in fluid external environments with coexisting professionals, the nature of these interventions, which are holistic and value-oriented, aims to enhance independent living. While this positions social workers with a sense of responsibility and contributes to their professional prestige, it also adds a fluidity to the type of interventions that the program is expected to perform.

3.2. Social worker as sociotherapist: The KETHEA case

KETHEA (Therapy Center for Addicted Individuals) is widely regarded as one of the most significant organizations in Greece dedicated to the treatment of addiction. It consists, to a certain extent, of self-governing communities dispersed throughout the country (Poulopoulos, 2012). The structure of the "recovery from addiction" program within KETHEA is often influenced by the professional perspectives of therapists. The formation of therapists' professional identity is marked by a series of individual changes that are considered necessary. In such cases, the boundary between professional career and personal biography becomes blurred, as professional detachment is weak due to personal and relational factors (Fragkiadaki et al., 2019).

The notion of self is recognized as a crucial aspect of healing and the commitment to the healing community within KETHEA. Consequently, social workers working in the addiction field undergo transformational processes as they assimilate into the work culture and assume the role and responsibilities of sociotherapists. Sociotherapists face challenges that necessitate cognitive assimilation and personal adjustments throughout

their professional development (Fragkiadaki et al., 2019). According to Beddoe (2011), this kind of work encompasses numerous interactive and ambitious domains such as social structures, civilization differences, work market, personal orientations and individual relationships. It also involves interdisciplinary collaboration in the field of care, which is exemplified by the work of KETHEA.

Social work traverses multiple interconnected and complex dimensions, including social, cultural, economic, organizational, and personal realms. These dimensions involve various types of social interactions within the work context and often necessitate interdisciplinary collaboration (Beddoe, 2011). Identity development in helping professions typically entails an exploration of the self, as viewed through the lens of Foucault's perspective (Foucault, 1984). Such self-transformation is often demanded by the work environment. The therapeutic orientations practiced within KETHEA in Greece likewise cultivate a similar relationship with the self, as the professional identity model of sociotherapy is proposed. This multidisciplinary approach to practice requires a partial relinquishment of "professional barriers" and a reshaping of professional identity to align more closely with the field of intervention rather than solely formal education and training (Ben Shlomo, Levy, and Itzhaky, 2012; Bosch, 1967; Levy, Ben Shlomo, and Itzhaky, 2014).

The professional biography itself becomes a tool for constructing a professional identity, a process referred to as "biographization" (Delory-Momberger, 2015). Transformations in collective and individual identities are often described as metamorphoses, characterized by movement and fluidity throughout different stages of development. Sociotherapists are encouraged to construct their professional identity through the process of biographization (Fragkiadaki et al., 2019; Delory-Momberger, 2015). Consequently, in such work environments, feelings of job satisfaction, adaptation challenges, or even fatigue are frequently attributed to emotional factors rather than narrowly structural aspects (Michalakoukos et al., 2011). As a result, tensions may arise between personal and work values, as social

workers find themselves needing to reconcile their formal education with the on-the-job retraining they receive (Wiles, 2017).

Reflecting on and aligning individual meanings and values with the organizational culture of KETHEA leads professionals to recognize that personal resources, emotions, social skills, and communication abilities are equally significant alongside the more specialized professional skills of social workers (Fragkiadaki et al., 2019).

3.3. Psychiatric reformation: community mental health services and social work

Similar developments are evident in the reformation of psychiatry, which reflects broader ideological and social processes. New norms in clinical practice emphasize the active participation of individuals, both therapists and those seeking treatment, in expressing their subjectivity and acting as individuals within therapeutic settings. In Greece, the transformation of therapy has been linked to a multidimensional process of individualization, particularly since the 1980s (Karydaki, 2019; Kritsotaki, 2016, 2018; Tzanakis, 2014). The transition in Greece from asylums to community-based care (Blue, 1993; Davis, 2012) reinforces the belief, shared in other contexts as well (Gavrilă-Ardelean, 2015), that therapeutic interventions should be based on communication with the person in distress, recognizing them as capable of conversation and negotiation. Focusing on the realm of everyday life in mental health, these broader social processes align with attempts to rebuild therapeutic relationships based on empowerment models (Linhorst, 2006).

This ideological and therapeutic shift has direct consequences for social workers working in the field of mental health in Greece. On one hand, their role is strengthened as the social dimension of psychiatric treatment gains increasing importance. On the other hand, the fluidity and diversification of community mental health present new challenges to their professional identity within the context of the division of therapeutic labor (Ambrose-Miller and Ashcroft, 2016; Jialiang et al., 2021; Heenan and Birrell,

2018). The project of rebuilding therapeutic relationships is seen as a fundamental model for reconciling with patients in the community, fellow mental health professionals, and individuals in general, intensifying the indeterminacy inherent in psychiatric everyday life (Khoury and Barrio, 2015; Linhorst, 2006). Within an open therapeutic relationship and intervention (Gavrilă-Ardelean, 2016), new terminologies and practices emerge, driven by the pursuit of new forms of self-regulation for both professionals and patients.

Different professional groups interpret the changing mental health field and the establishment of psychiatry "in the community" in various ways. Social workers perceive both the risks of delimiting their professional role and the expanding possibilities of intervention that align with their professional skills (Beddoe, 2013; Bland, Renouf, and Tullgren, 2015). Transformations in the structure of therapeutic relationships, in Greece and elsewhere, are directly linked to broader societal transformations in the 21st century. The rethinking of horizons within which therapeutic interventions occur is intricately connected to ideological shifts and collective interests, which focus on individuals' interior worlds and subjectivity—an area of knowledge that professionals such as social workers engage with (Brophy et al., 2015; Glajz, Deane, and Williams, 2017). It can be argued that transformations in the psychiatric field are closely related to wider reconfigurations of the welfare state. Within this framework, the individual emerges as a site of contested practices and discourses. The structural indeterminacy of roles prompts the search for individual points of reference, as long as social roles are not pre-defined or predetermined.

This “strake” does not imply directly to a social ontology, that could reflect the creativity of every personality. Instead, it emphasizes the establishment of institutional regulations and the articulation of discourses that call individuals to present and express themselves as subjects. In other words, it highlights the ongoing process of social regulation intertwined with symbolic struggles, which involve issues of power dynamics and social enforcement.

4. Conclusion

In conclusion, the broader social transformations, such as the multiplication of non-governmental organizations (NGOs) or the strengthening of the semi-public sector (Dedoussi et al., 2004), problematize the clear demarcation of professional roles, resulting in the multiplication of fluid environments where social workers are called to intervene. These developments are evident in various contexts, including the economic crisis, increased migration flows, and the presence of NGOs operating with vague time horizons and uncertain funding (Dedoussi et al., 2004; Georgoussi et al., 2003). As a result, social work posts have been created in these dynamic fields of action, elevating the professional status of social workers as valued members of the team (Dedoussi et al., 2004). However, the increasing fluidity of intervention fields makes it challenging to establish clear boundaries for professional roles, placing greater responsibility on individuals towards themselves and others (Barr, 2000).

Moreover, the logic of decentralization, a constitutive element of the contemporary ideology of the reformed welfare state. It is imposes a new normativity. While the central administration still maintains a dominant role, responsibilities are delegated to local services, particularly in the sector of social policies. This shift redefines the individual's role from "administrator" to a "responsible expresser" of welfare policies, emphasizing their active involvement in the application of these policies (Ion, 1997). As a consequence, local networks are formed, and individuals are expected to directly engage in achieving welfare policies, reflecting a "regime of negotiation" (Ogien, 1993). This reconfiguration of responsibilities challenges the traditional hierarchy and distribution of roles, as personal resources, experiences, knowledge, and capacities become valuable collective resources (Ion and Tricart, 1992). The indeterminacy regarding role descriptions is structurally imposed, fostering a sense of individual responsibility within an ongoing social regulation (Ion, 1990).

In this fluid and dynamic ideological and institutional context, social work is being redefined as a field characterized by fluidity in education and professional identity (Pullen-Sansfaçon, 2014). The liquidity that permeates

health and social welfare institutions problematizes the anchoring of professional identities, as social workers navigate through evolving contexts and practices (Mason and Evans, 2019; Morley, Macfarlane, and Ablett, 2014). The reconceptualization of therapeutic relationships, as influenced by broader societal transformations, intertwines with ideological shifts and collective interests, emphasizing the centrality of individuals' interior worlds and subjectivity (Brophy et al., 2015; Glajz, Deane, and Williams, 2017).

In this context, the social worker's role is strengthened as the social dimension of psychiatric treatment gains importance, but the fluidity and diversification of community mental health pose new challenges to their professional identity within the division of therapeutic labor (Ambrose-Miller and Ashcroft, 2016; Jialiang et al., 2021; Heenan and Birrell, 2018). Social workers in Greece, working in the field of mental health, are confronted with the imperative of rebuilding therapeutic relationships and engaging in a model of intervention based on empowerment (Linhorst, 2006). This therapeutic change has direct implications for social workers, as they navigate the tensions between their professional role and the evolving demands of the field (Beddoe, 2013; Bland, Renouf, and Tullgren, 2015).

In this liquid ideological and institutional context, social work is being redefined as a fluid field of education and professional identity (Pullen-Sansfaçon, 2014). Thus, liquidity, by permeating institutions of health and social welfare, problematizes mooring in professional identities (Mason and Evans, 2019; Morley, Macfarlane, and Ablett, 2014). In liquid times, intention to determine with absolute clarity the scope of practice and internal relevance of social workers' professional identity, is, to some extent at least, an open challenge for each professional.

In this liquid and dynamic context, social work is being redefined as a fluid field of education and professional identity (Pullen-Sansfaçon, 2014). Liquidity, permeating health and social welfare institutions, challenges the anchoring of professional identities (Mason and Evans, 2019; Morley, Macfarlane, and Ablett, 2014). In such fluid times, the intention to define the scope of practice and the internal relevance of social workers' professional

identity with absolute clarity becomes an ongoing challenge for each professional.

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Cultural Elements in the Evolution of the Sociology of Health and Diseases Caused by Food

– Literature Review –

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Health, which Robert Morse considers "one of the greatest riches of man", was defined by the World Health Organization as "a condition of physical, mental and social well-being." Maintaining a "standard of health [...] is one of the fundamental rights of every human being" (WHO, 1946). However, maintaining health depends on a multitude of social factors, influenced by the "degree of culture and civilization of a nation", by "social practices", and also by "value systems" (Rădulescu, S., 2002, p.8).

Hippocrates considered that all diseases are fundamentally the same, as they all have a material cause. This statement brings attention to a better knowledge of the "social problems" and of the social factors that degrade human health, through a thorough examination of the "social reality and consciousness" (Popescu, G., 1976, p.53). Consequently, along with

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fundamental sociology, several other branches have been developed, such as: "sociology of medicine", "sociology of culture and education", "sociology of food", "sociology of sport", each focusing on "approaching a certain social phenomenon" (Szczepanski, J., 1972, p.24).

The German physician Alfred Grotjahn (1869-1931) had an important role in the evolution of social medicine and the transition to medical sociology. Through his studies on detecting health problems from a social perspective, he created a new "theory of social pathology" (Freeman, H. E., 1963, p.45-47). In his work, "Soziale Pathologie" (1911), doctor Grotjahn laid the foundations of "sociological knowledge in the medical field", establishing certain principles, such as: "the significance and frequency of diseases", "the etiological relationship" between the disease and the social aspect, the social factors at the origin of diseases and, finally, the "prevention of diseases" and/or the "influencing" of their evolution through social measures (Rădulescu, S. M., 2002, p.32). Grotjahn realized that "disease prevention" (social hygiene) must become a priority, and his contribution to the process of developing social hygiene was felt throughout Europe (Rădulescu, S. M., 2002, p.33).

The concern for the prevention of diseases, since ancient times, has been a recognition of the fact that the state of health or the state of illness are not only influenced by biological factors but also by environmental and social factors. In this context, one of the main study objectives of social medicine is "the state of health of the population and its means of protection" (Coroi, V., Gorgos, C., 1980, p.4). We observe the birth of medical sociology by becoming aware of the imperative need for not only a "simple curative intervention", but also the implementation of preventive activity against diseases that affect a community. This involves the research of environmental pathogens (physical, chemical, biological), but also of the social aspect (Rădulescu, S. M., 2002, p.41).

The first Institute of Social Medicine was founded in 1943 in Oxford, England, and, later, in Edinburgh – a "department of social medicine", which aimed to study the "social aspects of diseases" through the prism of prevention (Rădulescu, S. M., 2002, p.41). Since then, the field of prevention

has been gaining new followers, and, in the United States of America, social medicine is regarded by Francis Lee Dunham (1925), as "a field of preventive medicine to which the social sciences must also contribute" (Freeman, H. E., 1963, p.47). Social medicine is beginning to increasingly appeal to medical sociology, and the field of public health has been defined by the World Health Organization as "the science of preventing disease, prolonging life and promoting physical and mental health" (WHO, 1963; European Union, 2019). Prevention includes not only "the study of the human body, but also the study of human collectivities, in their living environment, in their beliefs and life" (Petit, J. M., 1967, p.39).

Disease affects populations everywhere, but not in the same way, as Rodney M. Coe mentioned. The main objective of medical sociology is the study of diseases, how a certain group is affected, but also the study of lifestyle and the way in which disease is perceived by individuals belonging to a particular culture (Coe, R. M., 1970, p.1-2). Thus, the sociologist starts to become a "researcher in the field of preventive medicine", a "teacher [...] in sociology techniques", a "planner [...] of some programs [...] of development of the health of human communities" (Rădulescu, S. M., 2002, p.51).

One of the renowned contemporary sociologists, David Mechanic, "highlighted that the entire conduct of the sick person" can be determined by the social network. We must remember that "suffering has both an individual and a social dimension" (Mechanic, D., 1968). Nowadays, the risk of a disease aggravating due to lifestyle has increased considerably, but as stated by Dr. Jenna Macciochi, it was the "traditional lifestyles" that "shaped our health" (Macciochi, J., 2020, p.10). To be able to perceive well-being, we need a "balance between receptivity to new ideas", and "thorough research of old and new concepts" (Macciochi, J., 2020, p.11).

We are all born with a certain genetic heritage, on one side we inherit resistance and "prolonged state of health", and on the other side "premature wear and degradation of health and predisposition to disease" (Scarlat, M.-A., 2012, p.19). Our health depends on a multitude of genetic, environmental, social, and psychological factors, and on the quality of medical services. The genetic factor suggests that everything is "encoded in our genetic material" –

the rate at which we age, and the risk of developing the same diseases as our parents and grandparents. Nevertheless, it all depends on our choices, level of education, quality of the environment, food quality, and on cultivating and following pro-health habits. Environmental factors involve lifestyle, air quality, quality and access to drinking water, soil, healthy food, degree of pollution, addictions, climate change. Psychological factors such as mentality, spirit, character, and behavior of a person influence the state of well-being i.e., health. Social factors include family environment, social group, workplace, socio-demographic changes, situations generated by crisis, education, and, especially, education through prevention.

The improvement of medical services, an intensification of the collaboration between medicine and sociology, the development of prevention and curative services, the involvement of all education services, have as their ultimate goal a healthy society and, as a result, a prosperous society. Education for health, by choosing a healthy lifestyle, positive thinking, intensifying physical activity, adopting a personalized diet according to gender, age, occupation, but also rich in nutrients, brings "long-term benefits" for the entire society (Scarlat, M.-A., 2012, p.24).

Dr. Max Bircher-Benner (1867-1939) noted that a "wrong diet is the most feared invisible enemy of civilized humanity", and nutrition researchers "concluded that 70% of diseases are caused" by improper diet (Scarlat, M.-A., 2012, p.125). The quality of food is also given by environmental factors, air pollution, water pollution which "change its natural composition", demineralized soils, use of pesticides, thermal preparation, packaging (Duca, Gh., Mihaileev, G., 1995, p.12). Preventive education must include all the ingredients of a healthy lifestyle, which is the "foundation of disease prophylaxis", and all efforts must be focused on "knowing and overcoming the risk factors" that can generate the state of disease (Aşevchi, V., Racu, C., 2013, p.359).

In his paper "Lifestyle Tablets", Dr. Hans Diehl, with a PhD in lifestyle medicine, wrote that "the diet made up on the basis of common sense and balance [...] is the only diet the body really needs," and Dr Wiliam Castelli, director of the Framingham Study, stated that "the big problem [...] is to

educate and motivate" the adoption of a healthy lifestyle (Diehl, H., 2004, p.17). Only through education can we acquire knowledge about the "principles of nutrition", the causes of diseases, but also the "remedies", the understanding that "the decisions we make every day, every hour" determine or degrade our health, influence our well-being and our performance, and "being sick, has begun to become too expensive " (Diehl, H., 2004, p.18).

Man, "the most evolved being on earth" is unfortunately "also the sickest", and the factors that generate the degradation of the state of health, such as "hereditary capital, the environment and education", multiply every day. Education by all its means, the sociology of education, the sociology of food, have as their goal the development of the sociology of prevention, the maintenance of the health of a population, "as an index of social development", but also as a "decisive factor of influence on the economic, cultural and labor potential of society" (Natea, C. N., 2011, p.18).

Furthermore, the sociology and education of food should not neglect the cultural side of food. At the end of the nineteenth century, studies in the anthropology of food bring into focus the social aspects of food. The analysis consisted of the fine observation of "human behavior" in relation to food practices (Goody, J., 1982, p.30).

In his anthropological studies, W. Robertson Smith is concerned with "sacrifice", as "the offering that nourishes the living, as well as the dead" and the "effect of solidarity in society" (Goody, 1982, p.30). Another anthropologist, Sir James Frazer, mentions that "this is the idea that sanctifies the bond produced by eating together, in primitive societies" (Frazer, J., 1890, p.170). Emile Durkheim, in his work, "The Elementary Forms of Religious Life", states that "joint meals lead [...] to the creation of a bond of artificial kinship" so, once again, the social role of food stands out (Durkheim, E., 1895, Lungu, D., 2002, p.481-482).

In her monograph, Audrey I. Richards, a "pioneer" in food anthropology, pointed out that "hunger is the main factor that determines human relationships, first in the bosom of the family" and then, "in social groups." She also laid the "foundations of a sociological theory of nutrition",

and, as a promoter of food anthropology, she was concerned with the study of the nutrition of people of all eras, at the heart of anthropology being "the idea of culture and the notion that it represents the human species" (Richards, A. I., 1932, p.36).

In 1977, Leroi-Raybaut developed a study in the anthropology of food, where he emphasized the "consumption techniques", on the classification of the ways of processing food and the way of its preservation (Leroi-Gourhan, A., 1943). In "Handbook of Cultural Anthropology", Lowie (1936), introduced elements about food, "cooking techniques", meals, "but also manners of eating" (Marinescu, A. H., 2016, p.45). Lowie also showed that "the nature of meals" but also the "time", "differs from one nation to another" (Lowie, R. H., 1936).

In her "Manual for the study of food habits" (1941), Margaret Mead wrote that "food is, anthropologically, the first of necessities." In fact, it is at the base of Maslow's pyramid. However, the transition from the hunter-gatherer to the evolved man led to the modification and structuring of food, and everything that involves procuring, preparing, and consuming food "forms a structure analogous to other communication systems" (Mead, M., 1945, p.13/ Mead, M., 1997, p.21).

Anthropologist Claude Levi-Strauss, one of the most important representatives of the "structuralist perspective" and of the study of nutrition, studied the transformations that food preparation generates in the "framework of any culture" (Marinescu, A. H., 2016, p.48). Levi-Strauss also believed that "the cuisine of a society is a language in which it translates [...] its deep structure, or [...] reveals its contradictions" (Levi-Strauss, C., 1968, p.411). For Levi-Strauss, "language is a method used in the analysis of socio-cultural methods", later interpreted through the prism of "communication" (Marinescu, A. H., 2016, p.50).

Researcher Mary Douglas notes a connection between the "given social structure" and the "structure of symbols", and "bases social analysis" on the idea that "food" can be considered "a social code" (Marinescu, A. H., 2016, p.56). "Each meal is a structured social event that structures the others according to their own image" (Douglas, M., 1972).

Roland Barthes, in his work "Toward a Psychosociology of Contemporary Food Consumption" (1961) proposes the use of a "grammar" of food. He says, "if food is a system [...] we should make a census" of all the food-related behaviors "of a given society" (Barthes, R., 1961).

The first testimonies of Romanians' eating customs were given by Simeon Măngiucă and Atanase Marian Marienescu and can be found in Romanian mythology, in the "Collection of Folklore Customs and Beliefs" of Elena Niculiță Voronca (1903). In 1916, Mihai Lupescu, wrote about rural food, a work that would only be printed in 2000. In 1940, Ștefania Cristescu-Golopenția published "The Household in the Magical Beliefs and Rites of the Women of Drăguș (Făgăraș)." Sociologist and anthropologist Ion Chelcea was "the first researcher in the field of sociology" in charge of the study of food. Priest Simeon Florea Marian, in "Ethnographic Study" (1892) described eating habits at weddings and child christening parties (Marinescu, A. H., 2016, p.61-63). Thus, the "mythological school" identified that "the origins of the Romanian mythology and food habits" stemmed from "Roman traditions" (Larionescu, S., 2003, p.62). Other researchers in the field of food sociology include Dimitrie Gusti, who laid the foundations of "rural monographs", considering "the household [...] a phenomenon of social life" (Gusti, D., 1938, p.435).

A remarkable role in the study of eating habits belongs to Ștefania Cristescu-Golopenția, who, in the paper prepared in 1940 for the International Congress of Sociology in Bucharest, captured "the interesting aspect for both the linguist and the sociologist [...] of the magical language [...] with repercussions in the life [...] of the Romanian village" (Cristescu-Golopenția, Ş., 1940, p.6).

Romulus Vulcănescu (1912-1999), starting with 1938, has published several works of "cultural and social anthropology, [...] ethnography, mythology" (Marinescu, A. H., 2016, p.85). A work dedicated to the ethnology of the Romanian food was published in 1996 by Ofelia Văduva, who was "preoccupied with the relationship between food and the sacred" (Marinescu, A. H., 2016, p.89).

The French sociologist Pierre Bourdieu was preoccupied with the "sociology of taste." He saw "in taste and food practices" a "differentiation of the upper classes" and the "imitation of the lower classes", he also searches for the cultural differences of each social class (Bourdieu, P., 1979, p.200).

The food model is different from one "society to another", also being "the result of a culture, of a history" (Marinescu, A. H., 2016. p.161). Igor de Garine, defines these food patterns as "socio-technical and symbolic ensembles [...] that unite a human environmental group" (Poulain, J.-P., 2001, p.24).

Each society and each individual are the result of their own "choices and eating behaviors." They are at the junction between "biological heritage" and "cultural heritage" (Chiva, M., 1996, p.11-30).

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The Family as a System.
Brief Interpretation of Bowenian Concepts
– Case Study –

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Abstract: The family behaves like a system; this fact means that it is composed of several elements, called subsystems, which are in constant interaction. The existing pathologies at the level of the family system were approached differently by theorists. Among them, Murray Bowen, the leading representative of systemic family therapy, emphasized that the emotional dysfunction of an individual disrupts the entire family system (Murray Bowen, 1978). **Purpose**: We aim to describe a therapeutic approach by explaining the key concepts of Bowen's family system theory. **Results**: Despite the criticism of this theory (Brown, 1999), it outlines a clear framework of the mechanisms that govern family interactions and that allow the diagnosis of dysfunctions and their reduction through therapy. The struggle to restore the balance between fusion and emotional distancing is difficult and engages the individual's resources and resilience (Wylie, 1990; Eberhard-Richter, 2007). **Conclusions:** The case is relevant by underlining the importance of including the family in a process of re scenario of one's own life in order to consolidate and regain individual independence and autonomy; on this foundation, other social interventions aimed at increasing the well-being of the family can be implemented later.

***Keywords**:* family, system, Bowen theory, self-differentiation, boundaries, triangulation.

Introduction

In the social assistance of the family, not often, the specialists find an ineffectiveness of the interventions, determined by the limited access they have to the "essence" of the family (Gavrila-Ardelean, 2021, 2022). Metaphorically speaking, placing some benefits and services on a fragile foundation, no matter how diverse or efficient they are, often fails, not having the power to give the foundation solidity. That is why Berne (1961) focused on how the individual experiences contextual influences and Bowen (1976) and Minuchin (1974) were interested in understanding the situational variables that lead to dysfunctions in the family system (Massey, 1989). Family means more than a summation of members; to understand this fact, the expression or metaphor that I am referring to here is frequently used, namely: 1+ 1= 3 meaning that two people in a significant relationship experience this relationship "healthily" if they manage to keep each of their autonomy and it does not enter into a process of fusion, i.e. overlapping or dependence. That is, the relationship allows their fusion, common interests, convictions, common projects, implies constant adaptation to each other, but, besides the relationship itself, each person's relationship with himself is kept intact. The natural result 2, would mean that the two parties in a significant relationship still remain "untouched by the relationship"; result 1 indicates total fusion, it means that the two live the relationship by giving up themselves.

Family as a system. A short introduction to Bowen s systemic theory

Over time, several types of family therapies have been developed, the first of which was communicative family therapy (Wiener, 1949), followed by multiple family therapy (Cad Wells, and Peter Laquer, 1951; Gavrila-Ardelean, 2021). Other types of therapy are:

- Experiential therapy (Carl Whitaker (1955) and Virginia Satir (1951);
- Structural family therapy (Salvador Minuchin, 1974);
- Transgenerational family therapy (based on Bowenian therapy);

- Strategic family therapy (Jay Haley, 1976);

At the end of the 1960s, Muray Bowen proposed a systemic approach to the family, which changed the approach in psychotherapy and its general vision of psychosocial intervention. The family was perceived as a system, being made up of several subsystems, in a constant, particular interaction, which operates based on its own legitimacy. In Bowen's conception, a family commonly called "healthy", i.e. functional, is characterized by the fact that: it uses transactions that satisfy the needs of each family member and of the family as a whole. The dysfunctional family is the one that becomes rigid in an ineffective structure. Bowen identifies the existence of conditions that allow the good functioning of the family, namely: the existence of clear borders (limits), the absence of alliances or triangles, a well-defined hierarchy, known and accepted by family members (Mitrofan, Vasile, 2012).

Based on Freudian theory, Bowen observes that regardless of their orientation, therapists start from the premise that:

- In relation to others, there is an emotional disturbance
- This disorder is treated through therapy, based on the therapeutic relationship (Mitrofan, Vasile, 2012).

Functioning in this format, the members influence each other, the state of one spreads over the others, therefore, in psychotherapy, the phrase "child-symptom of the family" works. He can try to fix things, restore relationships, unify the parents, these steps having serious emotional costs. There is emotional unity in the family, says the author of the theory that introduces 8 particularly important concepts in deciphering the mechanisms of any family system, namely:

- Triangles
- Differentiation of self
- The emotional system of the nuclear family
- The family projection process
- Multigenerational transmission process
- Emotional detachment
- The position of the brother
- Social emotional process

The basic assumption of Bowen's theory is that chronic anxiety is one of the most important sources of dysfunction in a family. It is born as a result of a way of functioning for the individual that presents a low level of self-differentiation, respectively, developed a pseudo-self. He will not be able to remain authentic in meaningful relationships, he will show dependence and need for control. The too tight emotional closeness of the members, the disrespect of some limits and boundaries produces a fusion, that is, a kind of identity overlap, in which each one functions based on the requirements and needs of the other. This fusional state, difficult to manage, will still be managed, using four mechanisms:

- marital conflict;
- health or emotional problems;
- a child's health or emotional problems;
- triangulating other people in the relationship.

All families choose differently among these four strategies to reduce the level of chronic anxiety experienced by adults (Miller, Anderson, & Keala, 2004). Of course, a person can get out of this dysfunctional circuit, which means that he will go through a process of self-differentiation. This person will be able to adapt better to the environment in which he is, to identify dysfunctional practices and produce deep changes, and as a result to get away from stress and anxiety. An extremely important concept in systemic theory is the triangle. A triangle is created when one of the spouses uses a situation, a context, a person to relieve too much anxiety. If he chooses a person, then a large part of the anxiety will be transferred to him.

Bowen's systemic theory and especially the concepts and philosophy of functioning of the family system, have been challenged; some works have criticized and identified the limits of the theory, (Brown, 1999), others have suggested that there are results that support the idea that the level of differentiation of the self is a predictor of psychological health and marital quality and that there are positive associations between it and a more good physical health (Haefner, 2014; Titelman, 2014; , Calatrava, et al., 2022). Carr (2020) also suggests that systemic therapy has very good results despite the fact that it is quite rarely used in psychotherapeutic interventions. But it

undoubtedly has the merit of facilitating the understanding of emotional processes at the family level.

Based on these data, the goal of Bowenian therapy consists of:

• making the family system more flexible, accessing its ability to restructure;

• increasing the resonance of the family system, reflecting the sensitivity to the needs of each member;

• providing support for the implementation of family members' adaptive strategies.

Aim and Metho

We aim to facilitate the understanding of Bowen's theoretical concepts about family systems theory by applying them to family therapy. For this we use the case study as a specific method of qualitative research (Lietz, Zayas, 2010; Fortune, Reid, Miller, 2013). The objectives have in mind the realization of a diagnosis of the family, the identification of maladaptive mechanisms and the outline of some working hypotheses.

Description of the case

The P family requests help in solving their daughter's problem. The reason this family requested counseling/therapy sessions was the behavior of their 11-year-old daughter. The parents are concerned about their daughter A., who is always worried, agitated and emotional. Thus, the problem identified by the parents is their 11-year-old daughter's anxiety.

A first assessment of the family assumed the following aspects:

- describing the family system as a whole
- identification of subsystems
- identifying boundaries and hierarchy
- definition of responsibilities
- understanding the existing interactions between family members
- identification of coalitions.

The interviewed family consists of three members: father (D.) aged 42, mother (C.) aged 39, their daughter, A., aged 11. Dan declares himself a staunch family man. He spends a large part of his time with his wife and especially with his daughter. He actively participates in the girl's education, helps her with her homework, plays with her and satisfies all her wishes. He doesn't like to see his daughter away from home, not even at her grandparents'. Dan deeply appreciates his wife and says that he never stopped loving her for a moment. His parents gave him a good Christian education and material values did not and do not occupy the first place in his life. In this spirit, he also educates his daughter, A. Father is considered by his wife and daughter, the head of the family. And if he is unemployed, the family does not suffer because of this.

C. is a fulfilled woman, because she has everything she wanted: a husband who appreciates and loves her and a healthy, beautiful and decent daughter. Since their daughter was born, Claudia gave up her job (she was an accountant) and dedicated all her time to her daughter, of whom she is very proud.

Diagnosis

A. is a very sensitive and emotional girl. She feels best when she knows both parents by her side. Situations in which a parent is away worry her. She is afraid of situations where the parent might not come back, or something might happen to him or her. In such situations, Anda is sometimes overwhelmed by inexplicable head and stomach pains or simply cries. When the absent parent returns, the pain suddenly disappears, respectively Anda stops crying.

A. is very attached to her father. The mother says that the little girl adores her father and prefers to play with him than with her friends. When she was younger, A. often slept with her maternal grandparents. She especially enjoyed spending time with her grandparents. A year ago, A. found out from Gina (her best friend) that her parents are going to divorce. From that moment Anda refuses to be alone, she no longer goes to her

grandparents without her mother, she cries for everything (if dad is 10 minutes late from work). A. knows that her only duty is to learn. If she studies well, her parents satisfy her every wish.

Work Hypothesis

1. For Anda, the roles and boundaries in her family are not clear, and this reality gives her a lack of emotional stability.

2. After the discussion with her friend, A. is obsessed with the thought that her parents might also divorce, that's why she is so panicked when one of the parents is away from home.

Therapeutic intervention

After evaluating the family structure in which we identified the subsystems, boundaries, hierarchy, interactions between family members and coalitions, we established with P.'s family members a therapeutic relationship necessary to change the dysfunctional aspects. Through active and directive intervention, we created contexts and frameworks for discussion so that family members become aware of the way they interact.

In the last phase of the therapy, I resorted to family restructuring.

Subsystems

The following subsystems were identified:

subsystem – marital (D. and C.)

subsystem – parental (D. and C.)

subsystem – child (A.)

Boundaries - in this family the boundaries are diffuse. Authority and freedom are sacrificed for closeness and support. In this family there are no clear boundaries neither between members nor between subsystems. The members of the Popescu family are dependent on each other. They rarely have individual interests or ideas. At the same time, they offer maximum

support to each other. Dan and Claudia are very involved in their daughter's activities.

Hierarchy - at first glance, the power is held by the father, who ensures the family's livelihood. If we look at the life of this family from another angle, we notice that the total power is held by A. who, through all kinds of attitudes and tricks, has control over everything.

Responsibilities – Dan is responsible for providing for the material needs of the family. Both parents are responsible for the girl's education. Anda is responsible for the results obtained at school.

Interactions between family members – relationships between family members are open (warm), full of care for the other.

Coalitions

- between D. and C.

- between D. and A.

Discussions

Several elements of pathology could be identified (McGrow, 1996):

- borderline pathology; as I mentioned above, the borders are diffuse due to the overlap of the parent and daughter subsystems;
- the pathology of alliances: the father creates a coalition with the daughter, an adaptive cross-generational coalition, which, although it is not explicitly directed against the mother, is dysfunctional in that it compromises the rule-making system of the parents, which should be unitary;
- the pathology of triads: the father-daughter coalition that determines the construction of the triangle;
- hierarchy pathology: the family is led by daughter A. who controls the family environment through different strategies.

Therefore, the two conjugal partners managed to communicate safely once they attracted the third person, namely their daughter, creating a triangle. In this way, the anxiety felt at the level of the dyad (married couple) was somewhat relieved by the fact that all the attention and focus fell on

creating a life for their little girl. The girl's father created a coalition with her; a new dyad was created, which disrupts the individual functioning of each family member. The first dyad of any family is the married couple, and the limits and boundaries that delimit interests, relationships, freedoms, etc. in the family start from this subsystem, the parental subsystem (Abels, Lengeler, 2014). However, it is clearly observed that these boundaries are diffuse, which causes the daughter's anxiety (Barnhill, 979). The dependence of the family members maintained by the attitude of the parents in relation to their daughter is strongly felt by the girl; that's why she expresses the fear that her parents will not separate and the refusal to spend time with other children, in the absence of her parents. The family system, in this case, is unhealthy; it was also noted that, during the counselling hours, the father was seated almost next to his daughter, starting to be a support for any question addressed to him.

The parental couple is helped to understand that the hierarchy in this family is unnatural; the power belongs to the daughter, and that all events, actions, family life in general revolve around the girl's wishes. Always satisfied by the father, these desires become an imperative for the parent and a serious reason for the restructuring, disorganization of their daughter.

For A. The effort made in order to define oneself was quite difficult and painful; the exit from the triangle, the "comfort" created by the constant presence and support of the parents, the limited access to his father, the integration of some rules and their observance initially de structured the family, but, surprisingly, they understood the approach and the extremely important "stake" namely, the health of their daughter and the whole family. During the therapy session, they experienced another type of stress and anxiety triggered by the effort to adjust the belief system.

Over the course of three months, the parents noticed that, indeed, as they managed to implement the new rules in the family (which involved solving individual responsibilities), the daughter's symptoms disappeared. More precisely, she enjoys going out with her friends to play, she no longer shows phobia for the separation of her parents, she enjoys playing in peace. The two parents were helped to understand the source of their poor self-

differentiation, which is in the family of origin. They understood that they showed an important resistance in the failed attempts to free their daughter from the emotional pressure they exerted all this time. Satir (2011) observes that when parents emotionally invest more in each other than in the child, in the present case, the child feels better, freer. This is the practice that the two parents must apply. The table below contains a synthesis of the main processes identified at the level of the family system.

Table 1. The concepts proposed by M. Bowen, applied to the case under analysis

Muray Bowen Conceps	**Brief interpretation of the concepts in case A**
Self Differentiation	Low level of differentiation of self of spouses formed in the family of origin. This explains the dependence and the triangulation with their daughter
Emotional Triangles	the dyad turns into a triad when the tension in the marital couple is too tight; the married couple somewhat loses its role and turns into a parental couple. The mother-father-daughter triangle has an important role, reducing anxiety.
Nuclear Family Emotional System	A nuclear family emotional system used one of three anxiety-reducing mechanisms, namely triangulation. The girl's anxiety becomes a symptom of the anxiety in the cojugal couple.
Family projective Process	The married couple projects on the girl the expectations of closeness, recognition, intimacy expected from the partner
Emotional Cutt-off	The process of emotional cut-off did not occur in this case. Certainly, in the absence of therapeutic interventions or other events, there is the occurrence of distancing at the age of the teenage daughter, A.
Multigeneration Transmissions Process	The low level of autonomy, the inability to express oneself authentically in the significant relationships of the two conjugal partners, are trans generationally transmitted traits
Societal Regression	It manifests itself by indirectly limiting the daughter to spend time with the peer group or depriving her of the experience of spending time with her grandparents.
Sibling Position	There is no brotherhood subsystem

Conclusions

The complexity of the challenges faced by the family within the family system varies from dysfunctions due to dysfunctional mechanisms to problems of a social nature. Family assistance therefore meant a significant

expansion of these increasingly diverse and complex problems, being taken over by social assistance and psychotherapy. The integration of the two perspectives - the social and the therapeutic - offers a more comprehensive understanding of the scenario and a multidimensional framework for granting support to an institution like the family, which strives to remain a solid system, a landmark, a solid foundation and the premise for a healthy society.

The power gained through relationships, or empowerment, is the most powerful resource for any person or family at risk and is also the key element at the centre of the strategy to increase well-being (Khairunnisa, Noer, 2020). Self-help, the posture that in itself constitutes the purpose of social assistance, refers to increasing a person's capacity to take care of himself, to know, identify and access his own resources as well as those of the community; this self-help, which is based on an increased level of resilience, a life history that allowed the formation of social skills, is finally acquired, also through other people, caregivers, family, specialists. The role of the community is therefore fundamental.

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The "Oaza" Association / Charitable Organisation

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The "OAZA" Association is a Romanian charity, established in 1996.

When did it begin?

The association actually started its activity during the summer vacation of 1995, when Laura Andres motivated her friends to take croissants and milk to the children and young people that she had discovered in the Arad Train Station area. Throughout that summer he sought to discover where the street children were sheltering, to get to know the group and gain their trust. In a short time, the croissants and milk action turned into a hot meal delivered every day of the day.

Projects carried out since its establishment:

The Oaza Association was founded in 1996, by Mrs. Andres and her family and friends. It was necessary to create a legal framework in order to provide the right help to street children and youth living on streets. At that time, work was carried out on the street, where hot food was brought daily for 25-30 children and young people.

Among the services offered by the Association at that time we list: outdoor activities, recreational activities, counseling, legal representation, education for reproductive health, medical treatments, trips to the dermatology hospital in order to detect and treat children and young people affected by diseases with sexual transmission, visits to the local prisons or to

others in the country where the young people with whom the Association worked were imprisoned.

In 1997, the Association managed to purchase a building and rent another one in the village of Sânleani in Arad county. This is how Oaza started its child protection activity in the residential system, by opening two Centers, one for girls and the other for boys. The work was particularly difficult because the children and young people wanted the freedom they had on the streets, not a structured program so the volunteers of the Association faced problems for which they were not properly trained: substance abuse, children running away from the settlement, unwanted pregnancies, etc. The following year, the Association opened another center for preschool children, in the municipality of Arad.

Between 1998-2003, the Association also run a Day Center for street children in the municipality of Arad, through which more than 200 street children and young people from Arad or in transit through Arad received help. The center was open 6 days a week, during which street children and youth received a hot meal, possibility of performing personal hygiene by using properly equipped bathrooms or using washing machines to wash personal laundry. The center was a convenient place to offer both formal and informal education, counseling, health education, administration of medical treatments, to all those interested.

Between 1999 and 2004, the Association launched a project for young boys over the age of 18, in another part of the Arad county. The vision for this project had to do with the reintegration into society through work of those boys. The association focused, in particular, on animal husbandry and land cultivation. The project did not have the expected result due to the multiple and diverse needs of the boys. It was found that most of the boys did not keep up with the pace of life (although it was extremely slow and flexible) and opted to leave the farm. At the same time, there were also young people who immediately adapted to the program and did not part with it, becoming dependent on it. The project was taken over by another association in 2004.

In 2001, following the fact that a number of young women with whom the Association came in contact through the Day Center became mothers, and the children were placed at the Oaza Association, the specialists of the association formed a mini center solely for the protection of these children abandoned by their mothers immediately after birth or even left in the care of homeless people on the street.

In the Association's attempt to motivate young homeless mothers, prone to abandoning their children, between 2002 and 2004, a special program was run for these young women, in an apartment. There they had the opportunity to learn to be mothers and raise their children, receiving specialized help both from the association's staff and from doctors and psychologists. In this program, 5 mothers were co-opted for 2 years, with 100% success.

In 2004, the Association revised the way it provided social services. It promoted the fact that every child needs a family – the "Children's House is not Home!" Through its specialists, Oaza looked either for substitute families to assist the children or for the children's natural families to care for their own children. This was a desire Oaza had for a long period of time.

In the same year, Oaza timidly began to provide during the day support to children whose families were unable to cope with the challenges of keeping them in school.

In 2014, the Association ended its program of protecting children in residential system, directing all its attention to carrying for other categories of beneficiaries. In this sense, the Association proposed to provide the following types of services:

- Support group for mothers with young children - opportunity for mutual support, learning through play and gaining necessary skills for raising and educating children.

- "School of parents" type seminars

- Assistance service and support for homeless people (parents and children) through: social counseling, offering clothes and shoes, medicines and food, in special situations. The association collaborates with other non-

governmental organizations in order to find practical solutions/alternatives for these disadvantaged families.

- Services provided to the local community through the Day Center "Childrens Oasis" where an after school program is run for children from socially and economically disadvantaged backgrounds. In the center, in addition to recreational activities and spending safely their free time, children do their homework, serve a hot meal and learn various interesting things, all free of charge. It should be noted that the Association Center is unique in the Municipality of Arad in that it does not receive money from the local budget but it is financed by the goodwill of individuals or NGOs from Romania or Great Britain.

The "Childrens Oasis" Day Center is a licensed social service of the Oaza Association

Its mission is : offering alternative care and support services, during the day, to members of the local community, respectively to socially and economically disadvantaged families and their children. The mission is fulfilled by involving the beneficiaries in such activities:

• Education, recreation, socialization, social and psychological counseling, independent life skills training for the beneficiaries of the center

• Prevention of situations that endanger children's security and development

• Prevention of absenteeism and school dropout

• Prevention of juvenile delinquency

• Prevention of the separation of the child from its natural family and the institutionalization of the child.

Objectives of The "Childrens Oasis" Day Center:

- Increasing parents' responsibility for educating their own children and raising their awareness of the child's needs to develop in an emotionally stable family environment;
- Ensuring recreational and socializing activities that help them maintain the necessary mental and physical balance for individual development;

- Ensuring organized free time, as an alternative to exposure to exploitation, violence and delinquency;
- Increasing the degree of involvement of professionals from community services in the early detection of risks that determine the separation of the child from his family;
- Prevention of abusive behavior of parents and violence in the family;
- Improving school results for children;
- Training children in the field of respecting their rights;
- Involvement of the local community in solving the problems of children and families in difficulty;
- Providing support to children through educational programs appropriate to the age, the needs of the development potential and the particularities of the children;
- Ensuring the functioning of an assistance, counseling and monitoring service for both the family and the child;
- Providing goods to socially and economically disadvantaged families;
- Organizing courses for parents and other people interested in the growth, development and effective education of children;
- Ensuring a hot meal and some daily snacks;
- Prevention of social, school and family abandonment;
- Organization of clubs / workshops for non-formal and informal activities;
- Ensuring the care and safety of the child during his stay in the center;
- Child protection through the educational program carried out in the day center.

  Beneficiaries of the day center:

  1. Parents/extended families/substitute families who:
- requires childcare skills/skills adapted to the new psycho-pedagogical principles in the field,
- live in environments where models of child care and upbringing are practiced that do not correspond or are in contradiction with the models generally accepted in the community,

- ascertains the existence/occurrence of problems at the family level that affect the normal/harmonious development of the child or favors the manifestation of children's behaviors that endanger their family, social, school, professional integration.

2. Future parents who wish to train before the birth or adoption of children, by providing counseling and training at the Day Center.

3. Children who have developmental problems and/or integration difficulties in the family, school or community where they live.

4. Children whose parents are integrated into the labor market and do not benefit from supervision during the day.

5. Children reintegrated into their families or substitute families, during the period of accommodation with their new social situation.

Details regarding the building designed for the activities of the Day Center:

The building in which the Center operates was renovated in 2007, according to European standards. The building consists of 6 spacious rooms, a kitchen, a dining room, separate social groups for staff and children, rooms for storing various necessary materials, a yard equipped with play equipment for children.

The activities of the day center take place in specially designed rooms, equipped with appropriate furniture and sufficient didactic materials: reading books, notebooks, pencils, colored pencils, DVDs, CDs, toys.

In the classroom, 30 children from socially and economically disadvantaged backgrounds come to the Center after school. They get a hot meal and homework support. Through various partnerships with associations and foundations in the country, children are involved in recreational and socializing activities. What makes the "Children's Oasis" Day Center a special center compared to other similar ones, is the partnership with the Margaret of Romania Royal Foundation through which children interact with senior volunteers. Both children and senior volunteers enjoy the activities done together. Among these we mention: Gastronomy workshop, environmental knowledge workshop, sports workshop, reading workshop, nutrition and first aid workshop, personal development.

SECTION II.

Social Assistance and European Projects

Strategic European Erasmus + KA 2 Projects and their Importance for the Field of Social Assistance

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Abstract: The article reviews the ongoing European projects of the last 5 years in the field of social assistance, in which our university is a partner. The university manages these projects at the national level and creates new professional tracks in the practice of social assistance through the research part. Social workers, master's students at the level of the Social Assistance Services program of the Aurel Vlaicu University in Arad are directly involved in the implementation and training of the Erasmus + KA2 strategic programs.

Social Work Through European Projects at the Aurel Vlaicu University of Arad

1. Functional Methods in Teaching and Therapy KA 2 – Strategic Project 2020-1-FI01-KA202-066555

The aim of the project

Our purpose is to guide the youth towards a more active lifestyle by encouraging healthy physical exercise, both in school-related and home environments. By cultivating positive experiences, we aim to strengthen

their desire to become physically active and adopt an active learning strategy.

To promote physical activity in young people, we search to develop new teaching methods, through a functional approach, by integrating the best practices from multiple countries to obtain a single, innovative system.

Project Partners

The project assembles seven European organizations, with a common scope – bringing together the best teaching practices from every participant's country, for all age groups – starting with early childhood education and continuing through high school and vocational training.

Results

As a result of this project, new and innovative teaching methods will be developed. Providing educators and trainers with these tools will lead to a more effective teaching environment, across Europe.

In addition, educators and trainers may incorporate physical exercise methods into their daily work schedules, thereby increasing the quality of life at work.

2. 'The Citizen's Empowerment in Mental Health: from the ideas' laboratory to the operational perspectives for the self-determination of users' KA 2 – strategic project Empow'Them Project 2020-1-FR01-KA202-080436

The aim of the project

The project aims to improve social inclusion of people with mental health disorders, by developing self-determination and empowerment – two essential concepts for mental health promotion.

Furthermore, it seeks to enhance the emergence of self-determined behaviours of users by improving the support skills of professionals active in the field of mental health (caregivers, educators, attendants, etc.).

Methodology:

- Design continuous, free and directed training for all professionals to enable them to better support users towards more assumed, more self-determined behaviours.
- The educational system is inspired by reverse pedagogy and is the heart of our project's innovation.

Project Partners

Results

The Empow'Them project ensures that mental health users are respected and treated with dignity, as a result of implementing professional practices that enhance their freedom of choice.

3. Digital Learning IN SOCIAL Intervention KA 2 – strategic project DLIS Project 2021-1-FR01-KA220-HED-000027512

The aim of the project

- Developing educational strategies to fight the digital divide;
- Raising awareness of the role of digitalisation in the social field;

- Training the next generation of social work professionals is an anchor for developing digital uses in social and educational support;
- These accompanying practices make the user autonomous, eliminating the exclusion caused by the digital divide.

Project Progress Assessment Categories.
Types of Digital Indicators Evaluated

- Indicators of digital achievement
- Indicators of digital performance
- Indicators of digital knowledge impact

Project Partners

Results

Development of course modules for Social Work master's students that will allow them to acquire digital skills to train beneficiaries of social assistance services in remote communication.

The ability of users to communicate with social work specialists remotely, through digital means, is part of the social and educational support they receive, to promote the social inclusion and the personal autonomy of users.

Conclusions

The involvement of students in European projects leads to the training of research skills and the training of new skills in various specific levels of the field of social assistance. These skills will be useful in their

professional and personal development, so that they will be able to go towards research subjects in which to obtain applied results in the social field of nursing practice.

In addition to research skills, the social worker also acquires transversal, international communication skills, in a foreign language, through multicultural interactions with partners from the various countries participating in these projects.

The social worker will find new solutions to the new and complex problems raised by an international project.

These dimensions of the activity in the projects will lead to the personal development of the specialist, which can go up to the social enterprise.

Evaluative Analysis of Management in European Projects on Social Issues

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Introduction

The European project IT4Anxiety strives to implement digital solutions to reduce anxiety of patient who suffer mental disorders. In the context of e-health development, the actions of the project bind together mental health professionals, startups, universities, research centers et higher education establishment across North-West Europe. The project brings together 11 partners and sub-partners:

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psychiatric hospitals, universities, universities, etc. from 4 countries of Western Europe: Belgium, France, Northern Ireland, Luxembourg (De Moffarts, 2022).

The use of innovative digital technologies appears to be an effective complement to more conventional therapies, including chemical therapies (Briffault et al., 2018; Morgiève et al., s. d.). The complementarity of digital and non-digital therapies is called "mixed" or "hybrid" therapies. These mixed therapies are supported by the project's activities which aims to co-create and test at least ten solutions for patients suffering from anxiety.

IT4Anxiety consists of three main modules (Work Packages), which constitute its main objectives. The first module assesses users' needs as part of a vast international survey. The survey is used to define the framework for the national hackathons where innovative start-ups and their digital solutions are recruited. The second part is entirely devoted to helping start-ups implement, test and validate their products. The third is an international online training course to support cultural change in e-mental health and the use of combination therapies. The other modules (communication, management and sustainability) provide support for the implementation of the project.

The place of the evaluation rose early in the project. As an European project, it must include several criteria and indicators related to its objectives and target. Mainly, the management must prove that the project has reached its targets by counting the proves and making comparison by quantitative indicators. This evaluation is about “how much you do” regarding “how much you have planned”. This kind of evaluation assesses the efficacity of the project and strengthen the technocratic control by European Union, as the founder has the legitimacy to know what the projects has done with the public money.

The evaluation process lacks of another kind of evaluation. Following Stufflebeam’s well known sentence : “evaluation is not to prove but to improve”. In the IT4anxiety, leaded by technocratic habits, the evaluation was only a way to prove. If proving could be legitim, it comes at the end of the project, to late to use the results of the evaluation for regulation and improvements of the project. To prove is an ex-post evaluation, but the project needs an itinere evaluation to sustain decisions and redirection in its

course. We named this “evaluative analysis” in the project to make a significant difference with the other kind of evaluation (Absil & Fond-Harmant, s. d.).

How could it be possible to introduce another kind of evaluation more focused on the improving ? This chapter is contributes to explain how we set an evaluation focused on improvement. Its shows also the results of the midterm evaluation have been used to regulate the project. This evaluation was built up upon a participatory methodology. This methodology benefits to the project management because it provides *in itinere* information to facilitate the regulation of the project and to sustain the quality management. This chapter begins with the framework of the evaluation. By framework, we mean the evaluative questions, but also the criteria and the indicators that allow to give documented responses to these questions. It begins with a look at the process that led to the choice of the questions. In this part, we also precise our definition of the evaluation process and its finalities. The second part presents the evaluative questions and the stakes that they could raise for the project IT4anxiety. The next part presents a first overlook on the results. What are the temporary results at this time and on the basis of the available data? We shortly conclude with what we perceived about the stakes for the next months. The main text is completed with methodological and conceptual precisions.

The way the project manage a place for an alternative kind of evaluation is a political act. Evaluation is nowadays too much restricted to the measuring of the performance by quantitative indicators. IT4anxiety try to set an evaluation process at the opposite. As human actors the partners need to give meaning to their involvement in the project and to their action. This meaning could not be limited to a “number of”. It must be framed within some social and ethical stakes. What is the meaning of counting the assistance ? Does it say anything about the participation ? The IT4anxiety project promotes implicitly a technical vision of the society where the mental disorder could be cure by technology. Because of this technological scope, the project has to pay attention upon the social meanings and effects of these technologies. As the word of Lock, the project could not be of process of

"technological somnambulism" in which the technologies are fabricated and promoted without any social and ethical reflexion, without trying to explicit all the stakes, like we walked in a waken dream.

Since the beginning of the project, it seems to us that two major themes are recurring in the meetings and documents that concern the evaluation. The first theme is about a shared culture about e-mental health. This theme may seem obvious: actors from different universes of sense who are brought together in a project will have to get on with each other in order to work together. The project engages in the field of innovation in mental health. But what are in fact e-mental health, blended therapies, anxiety, disorders, ... Is it so obvious to agree on these words which are also practices whose concrete implications could deeply transform the care and support relationships in the field of mental health, and more particularly in psychiatry?

The definition of a culture between the partners is not done in the closed field of a project turned in on itself. IT4anxiety is a project linked to the social worlds (professionals, users, carers, organisations, political decision-makers, etc.) which are not without culture and experience in the field of mental health, disorders and the use of technologies. IT4anxiety is linked to the pandemic, climate and socio-economic contexts which have themselves transformed the relationship to technology, but also the attention to mental health. This means that the culture of e-mental health composed by the partners takes, through attention to the users, these social contexts into account to produce a version of e-mental health that composes between therapy, health improvement, updating of professional practices, numerizing and digitisation, ethics, economic development, digital divide, empowerment of users...

The second concerns the way in which the partners, the sub-partners, the start-ups and the allies of the project will organise and articulate themselves to allow an effective meeting between the worlds of psychiatry, pedagogy, users' experience and the development of quality digital tools, all as care devices. This theme is linked to social innovation. Somewhat

provocatively, the IT4Anxiety project could more easily be recognised as a social innovation project, than directly as a technological innovation project. Or, to put it another way, the social innovation component could be more important than the technological innovations. To analyse this hypothesis, we need to return to a definition of social innovation as a capacity to bring together actors from different, sometimes very distant, worlds to support social progress (and including better mental health).

If the roles of an evaluation are "to improve" (Stufflebeam et al., 1985)), "to valorise" the value of projects and "to be centred on use" of the results (Alkin & Christie, 2004; Patton, 2014), we betted that: "the production of a shared culture of e-mental health which takes into account the many societal issues and the quality of the social innovation process" could meet these two roles.

Evaluative analysis process

How do we define the evaluative analysis?

There are many definitions of the activity of 'evaluation'. It's not the place to present and discuss it all, but we would like to situate what we call evaluative analysis in this project. Evaluation process is always at the crossing of research, action and politic. As minimal definition, evaluation could be "a social process to give answer to questions with the finality of taking decision". This is a definition to accentuate the action and politic dimensions of the process. But evaluation process must also support action and politic based on methodologically constructed data (Demarteau, 2002).

The evaluative analysis aims at providing to the partners and all the stakeholders a documented point of view about the project. This point of view is not one of the evaluator's only, that would be too much subjective. Instead, the process tries to conceive the evaluation as a space of intersubjectivity, a space where the points of views of the partners could be crossed to build up a collective point of view (Hodge, 2005). The collective point of view needs to identify what could interest the partners, what

questions could be useful to be answered about the project, what questions could valorise or help to manage the project IT4anxiety. That's what we define evaluations as a social process. In other words, we embed the evaluation in a constructivist paradigm that valorises the need of crossing the points of view, but also social representations and everyday life experiences, to access to reality (Absil et al., 2012; Fetterman, 2001).

The role of the evaluator is variable (Volkov, 2011). The first task is to identify the stakes and the evaluative questions. This task must implicate the partners to ensure that the evaluative questions are sufficiently intersubjective. After supporting the choice of the questions, the second task is more technical. The evaluator sets up the collect and interpretation of the data. In terms of ethics, in the framework of this type of evaluation, it is recommended that the evaluator ensures the transparency of the evaluation by submitting documents, notes, synthesis, conclusions to all the partners involved in the project.

To keep the relation with the partners, and to continue to work with the collective point of view, the evaluator must provide short reports about his work. Each report is an occasion for critics, debates, clarifications, mid-term decisions… In our mind, the point of attention will be the collective validation of the mid-term report and the final report.

The evaluation methodology and framework

What is this evaluative analysis about? This evaluative analysis focuses on the project. The project is an arrangement of work packages and partners linked together by a web of activities driven by the project objective. We state that work packages could be the good scale for the evaluative analysis. When the partners speak about the project, they mention it in relation with the "WP", when the project communicates about itself the communication focus on the "WP". If we take partners as the evaluation scale, the evaluation is at risk to produce control or appreciation upon the partners. That's not the kind of evaluation we promote, it's not audit. If we take "actions", we take risks to crumble the project in a too analytical way.

The “WP” seem to be the right unit to ground the evaluative analysis in the “systemic of organisation”. IT4anxiety is not conceived as a simple sequence of action, that could be modelled as A=>B=>C as many input/ouput action theory. The work packages are linked in cycles of activities. The successions of the cycles of activities generate the road to achieve the main objectives. As in many projects, the first cycle of activities could be seen as a learning start from which the other cycles could find resources, lessons, ideas, good practices and also rejected practices. The successions of the cycle fit with the quality management circle (Plan, act, check). The project is also complex because it creates an innovative “space” between different worlds around the stake of e-mental health applied to anxiety and PTSD. The project connects a great variety of cultures and organisations. In terms of system, the project is open to its environment because of the startups recruitment and because of impacting the implementation of blended therapies (Le Moigne, 1990) . It’s very hard to show the systemic process of this project without to be drowned in a mass of data. The Le Moigne visualisation of complex system gives an opportunity to do so. This visualisation is also some kind of evaluation of the quality of the system. If the project effectively fulfils all the functions of the system, by theory of system, we can presume that the project is consistent enough to impact his social environment and be sustainable.

If the evaluative analysis is “intersubjective”, it assumes the need of the participation of the partners in the process. Participation is also a part of the political aim of the evaluation process. In the case of IT4anxiety, the participation in the process could be unstable: just because we work with the real constrains of the partners (Jacob & Ouvrard, 2009). But we try to preserve the participation through all the process. Taking participation into account leads to slow down the evaluative process, mainly at the beginning. In a world of acceleration (Rosa, 2010), it could be perceived as counterproductive and being lacking efficiency. Two main arguments could be raised against these. The negotiation about the evaluative process takes time but it could strengthen the usability and the interest about the result. The evaluative analysis answers to a matter of concern (Dewey, 1927). The

questions are linked to the real work of the partners. They are linked to the quality of the process that could not be addressed by an evaluation of the completing of the objectives. The interactions between the partners in the space of the project add more than just producing results. In fact, this intersubjective negotiation is of great quality because of the variety of points of view that come together.

This evaluative analysis is mainly done by using a qualitative methodology (Patton, 2014). To us, this methodology seems to fit with this complex project. Methodological literature points out the interest of a multi-sites methodology to analyse and evaluate such a project (Garsten & Nyqvist, 2013; Marcus, 1995). Qualitative methodology uses qualitative methods for collecting (interview, documentation, observations) and analysing data (hermeneutic, coding process, …). We opt for an ethnographical approach that combines observation, interviews and documentation analysis. The data are mainly textual and need adequate analysing process (Ladner, 2014; Smith, 2005). We assume that qualitative method means nothing without sociological background. This evaluative analysis is embedded in the sociological theory about the organisations. The "ethnomethodology" is a micro sociology about the methods used by the social actors to achieve their purpose. It asks "how" the partners use methods to implement the project, the goals, and the activities. When you do something alone, but also with other people, you use homebrew theories and methodologies (Garfinkel, 2009).

These homebrew theories and methodologies allow us to better understand: which are the criterions used by the partners to take decision to solve task in the project? Microsociology is often criticised because it does not draw attention to the social context (Cicourel, 1964, 1974). So, we need to have another lens to observe the project, a lens more adequate to observe the project as an organised system. This lens is provided by the sciences of complexity, mainly the "structured complexity model". The arrangement between the two lenses seems to be a convenient solution to have a more complete evaluation of the project IT4anxiety.

At this time, we collect data by observation and documentation analysis. So, our access to the project still depends on the access to the sources. That's why this report may seem a partial view of the project. But we engage you to remember that evaluative analysis is not research. It's mainly a documented point of view, from the evaluator, about the project (Cefaï & Cefaï, 2010).

The evaluation framework is simply the convenient presentation of the questions and the criterions/indicators. It is not only a matter of technical or of research process. The criterions are truly the yardstick to build the evaluative judgement about the questions. That's why, and particularly in a plurilingual setting, the framework provides a definition for each criterion. We present here a first version of the evaluation framework. Why a first version? The evaluation framework must be discussed we the partners. The arrangement of questions/criterions/indicators is technical or scientific. The arrangement is foremost a question of sense and therefore of usability and understanding. A good evaluation framework could become a production of the project; because it could transform into a more general evaluation tool for whom would decide implement e-mental Health. The evaluation framework is visualised into a table. The evaluative questions are in the first column, the criterions in the second and proposal of indicators in the third one. Two other columns complete the table, one for needed data and the other for an eventual inquiry method. This framework needs a collective validation by the partners, otherwise the evaluation could not achieve its two finalities of "improving" the project in itinere and valuing the productions.

To find evaluative questions, we have analysed the data we have been acceding to since the beginning of the project. We gathered information from observations, discussions, and documentation analysis. All these information's were analysed by coding process to identify patterns, theories, and methodologies (in an ethnomethodological sense). A first set of questions was submitted to the partners (participation). Some partners reply by using the form another was met in discussion. The main result of the partner's advice is a more accurate formulation of the questions, a better understanding of the stakes linked to these questions and the identification

of a new questions. The advice of the partners allows us to make an "abacus" to visualise the consensus and dissensus about the questions. Finally, we wrote a note about the evaluative questions and we are checking a last validation by a form (Fetterman, 1986).

Criteria are mainly provided by mainstream (OECD, E.U.,…) evaluation guidelines. These criteria are relevance, coherence, effectiveness, efficiency, impact and sustainability. These criteria are very normative, external, abstract, and meta. In fact, who does think about these criteria in the everyday work? In fact, they conduct to an abstract set of evaluative questions. In this evaluative analysis, we think the criteria are already present in the action. They are present in each decision, even micro decision, that makes the project work. Sometimes they are clearly expressed, sometimes they are latent. Instead of using abstract criteria, we aim to use the criteria which the actors truly use. Cognitive sociology, but also ethnomethodology, gives a solution to observe these criteria. To create the evaluation framework, we need to better understand and identify the "natural" criteria used by the partners. The criteria emerge from a textual analysis focus on this question. What are the criteria which are used to deal with this situation? Doing so, we are still aware to not misinterpret the word. That's why latent doesn't mean hidden and why we cannot imagine criteria if there are none.

Results

Evaluative questions: actors' point of view

The first part of our result are the evaluative questions. The observation of the work, the reading of the documentation, the conversations with the partners lead to identify a set of questions to build up the evaluation process. All these questions where discussed and negotiated with the partners at the beginning of the evaluation process. We present the questions as a result because they set the frame of norm and values use by the partners to talk about the project outside the technocratic evaluation. For each

question we provide some explanation about the stakes for the project. These stakes where discussed with the partners. The criteria and the indicators used to evaluate each question are also a collective production with the partners (see annex for complete list) At first sight, the questions appear to be very interlinked so they could be arranged is many ways that could make sense. The arrangement of the questions is also a matter of communication and valorisation of the project.

Table 1 : synthetical view of the midterm evaluation

● reached ◒ almost reached ○ not reached ◌ need other information	
Q1. How high is the user's participation in the project?	
Crit	Indicators
1.1. The people suffering from anxiety (illness/sickness/disease) have the higher level of participation on the Arnstein scale	●●●●◒○○○○
1.2. Person who cares and lives with people suffering from anxiety have at least a citizen participation	○○○○○○○○
1.3. Professionals of mental health care participate at least as much as citizens	●◒◒○○○○○
1.4. Professionals of the start-ups participate at least at citizen level	◒◒◒○○
1.5. All the partners participate in the project	●●●
Q2. How does the project manage to build an alliance for the promotion and the implementation of e-mental health? How does the project construct a shared culture about e-mental health between the partners?	
2.1. IT4anxiety can recruit, associate new stakeholders in a variety of fields	●○○
2.2. Partners or sub partners diffuse the project	●●○
2.3. IT4anxiety provides support to advocacy about e-mental health	◒◒
2.4. The partnership could last after the project	●●○○○○
2.5. The project has a proper visual identity	◒◒
2.6. The partners have built a common vision about e-mental health and blended therapies	●●○○
2.7. The partners manage to compose with the definition of "anxiety"/ PTSD	●●●
2.8. The partners have some values in common	○
2.9. The partners use a common vocabulary about e-mental health	●●●
2.10. The objectives of the project are well known by the partners	◒◒●●
2.11. The project manages to link transeuropean scale and local scale for the actions	●○○
Q3. How does ethics play and act in the project?	
3.1. The ethics committee is sought and its opinions are communicated	●●○○
3.2. People suffering from anxiety are not stigmatised or labelled	●◒::

● reached ◒ almost reached ○ not reached ○ need other information	
3.3. The socio-economic accessibility of the blended therapies is taking in account	○○○○
3.4. Ethical concerns have a role in each work packages	●●○○
Q4. How to link the actions between the different work packages	
4.1. IT4anxiety has an explicated theory of action	●●
4.2. Partners share resources, whatever their nature	●●●●●
4.3. Partners are involved in several work package	●●●●
4.4. Partners manage to start the project on a solid basis	●●
4.5. The project allows partners form different work cultures and settings to work together	●●
Q5. How are the start-ups supported with their innovative solutions through the whole process (co-creation, testing, validation) until entering the market?	
5.1. The project facilitates the identification and recruitment of start-ups that propose high quality or potential high quality blended therapy	●●◒
5.2. The start-ups included in the project are satisfied with the support	◒◒○○○○○
5.3. The support process to improve the quality of the products	◒◒◒
5.4. Start-ups understand the procedures for entering the medical market	◒◒◒

How high is the users' participation in the project?

This question appears to be a high stake for the project. In the formal aspect of the project, the knowledge of the user's is the ideally start point of the selection, inclusion and supporting of the IT therapies. This stake also appears in informal interactions as the partners are aware of the user's participation when they discuss or implement the actions. The response to this question could valorise the project and its production. In the field of public health (that includes mental health care and cure), the participation is a criterion for the quality of the project. This question must be discussed, and this discussion will have some consequences for the evaluation framework. Users is a very "trap word", we must always remind that user means people who suffer from anxiety, professionals, and family carers. The users have a form of commitment in the project by the mediation of the partners' institutions. Potentially, each partner can also think himself as a potential user. To situate the need between the world of the users is not as simple as it seems. This type of users is a still very large category. If users are the patients, that's very different from the users as everyone who suffers from anxiety. Participation is also difficult to discuss. Taking the needs into account is

certainly a way to impulse participation to the implementation of blended theory. But the participation scales are more complex. The classic one (Arnstien) and mostly used in the field of health identify eight levels of participation classified in three main types of participation. The two first level (Manipulation and Therapy) are called Nonparticipation. The levels 3 to 5 (Informing, Consulting, Placation) are called Tokenism. The three last levels (Partnership, Delegated power, Citizen control) are called Citizen Power.

Users? Participation? A look to the "form"

The words "user/users" is frequently mentioned in the application form. It can vary: user/s, end-user/s, mental health user/s, PSD and Alzheimer's users, users facing Alzheimer or PTSD, users facing anxiety, end-user's needs, users-centred, users' families, user's point of view, users (= mental health patients, mental health beneficiaries), "usagers" (French), "diagnosegroepen" and "patiënten" (Dutch).

Users is a high polysemic word in the project. There are two main significations in the form: (1) users are ill persons (Alzheimer or PTSD) that face anxiety, (2) users are the people who will use IT solutions. The form distinguishes "users" from the caregivers, professionals, and families. This distinction is not so easy. In the inquiry about evaluative questions, an association points to the restrictiveness of this label "user". From this point of view, families but also professionals - must be considered as users. The arguments mentioned the facts that families also use the services and, in some cases, will use the IT solutions. An attention must be paid to the difficulties about the framing of the target public, especially in the WP2 and WP3 which are very concerned by practical needs of the users. As the Swot analysis mentions it: "users" became a too wide target for concrete implementations.

This polysemy arises during the project when, because of local constraints in each country, partners realise that the target public was not so reachable. This difficulty generates discussions to find practical solutions to

attract users whose profile fits the project's objective. The WP had to cope with the polysemic "user", and in fact most of WP must take into account at least the points of view of patient, professional and families. Doing so, the WP acts as a support to cross different needs, expectations and everyday life experience of mental health and e-mental health devices. The way each WP manages this crossing to support the implementation of mental health could be seen as a fundamental course of action. In the case of IT4Anxiety, the well-defined target public in the form does not resist real constrain and generate an important work for finding ad-hoc solutions. But, remember that is a mid-term deliverable, and that the target public could be reached in many other activities in the next years.

The meaning of participation is unclear in the form. In many objectives, participation means the implication or commitment of the partners or the stakeholders in the activities. The user's participation is qualified as "active" in the case of the tool's development. For Patient association (sub partners), the matter of participation is to "bring the point of view of the users' families in the project's implementation" (WP2) or to co-construct the training process (WP3). We find other words about participation. The cultural change needs a "co-construction" (French), a "co-creation" (English) or a "co-constructie" (Dutch). The tools are co-created with the users. In relation to the users, participation is mainly a process of co-creation of the tools. Relative to users' association as stakeholders, participation appears to be a commitment to the activities. The difficulty of "Co-construction" is that this word is both process and quality criteria. Concretely: what is "co-construction" in the project IT4anxiety? In which theorical, political, pedagogical could it be embedded? The lack of a clear definition is not a great problem for the structure of the project. It's more a question of valuing the project. We must constate that the "stake of participation" has been existing since the beginning of the project.

How high is the participation to decision taking in the project?

Levels of participation are very political topics, and the project aims to enhance commitment of all the stakeholders and partners: including users' associations. The user's association are sub partners of the project. Because of this status, they seem not to be not included in the management of the project. If we analyse the PV of the Steering Committee, the users never assist to this strategic place. The steering committee is still the right place to be informed about the progress, the stakes, and the reorientations of the project. As they are sub-partners, the user's association have access to the documents of the steering committee. But we do not certainly know if they consult them. At the beginning of the project, the linguistic accessibility to the documents, but also to the discussions, was raised by some associations. Likewise, they aren't present in the ethics committee. Whereas the ethics committee is also an important place where decisions are taken about IT solutions. ◎ Therefore, regarding the co-creation the user's association could gain more power and recognition if they were more included in all the strategical decisions process in the project.

Probably, the COVID-19 situation doesn't help contacts between user's representatives and the partners. Local meetings, hackathons could be the places for such meetings, for organising discussions with user's representatives, as it was the case in Amsterdam.

Nevertheless, the user's associations are present in some of the activities. They were actively present in the kick-off (Amsterdam) where they gave their point of view during the workshops. They were present in the hackathon in Amsterdam where they were members of the jury.

When they are not "really" present, they are represented by the partners who really care about the user's point of view. The quality of the representation is insured by the habits of the partners to work with users. Some of the partners have this serious role in the discussions: to bring the point of view of the users as ill person or as professional, to make their voices audible, to give access to this point of view to partners lesser linked with the users of mental health as the start-ups mainly are.

In the scope of our observations, we have gathered some information that confirm this serious role. As cases, this role was played in the WP1 during the organisation of the inquiry about the needs. WP1 is all about the user's points of view. The inquiry aims to understand the needs and the uses of user's suffering from anxiety. In terms of process, WP1 is the "project unit" where a representation of the user's needs should be constructed upon the basis of focus group and questionnaires.

The point of view of the users is an objectivation of their needs and their uses from an anthropological and comprehensive perspective. "What does the user's suffering from anxiety tell about? What do the user's suffer anxiety from? Why and how?" Reporting to Le Moigne, the WP1 would assume the observation function. The practical organization of the inquiry in each region was a moment of negotiations about the meaning of the label "user', as we will discuss it in the next evaluative question. The inquiry methodology must be adapted to fit the possibility of each partner. Regardless of the meaning of "users", the partners care a lot about the feasibility of the inquiry in taking into account the capacities, the availability and the constrains of the users. WP3 (training) also gathered information about the need of the users to develop the training.

How does the project manage to build an alliance for the promotion and the implementation of e-mental health? How does the project construct a shared culture about e-mental health between the partners?

The commentaries of the partners have us merge the two questions. Indeed, alliance is about shared culture and shared culture is a part of the alliance. The definition of alliance is grounded in military and diplomatic language. It means the combination of the strength to achieve goals. This definition is also about the idea of "community of interest". We think that the concept of alliance is not merely the concept of networking, which could be a better way to address question 3.4.

The shared culture is many things. We define it as "something the partners have in common when they refer to the project". In fact, the project

links many types of cultures: professional, medical, lay knowledge, language, social organisation, history, … The hypothesis is that the partners must create "a common culture" to be able to work together (e.g., labelling the users) and to promote the project across Europe and in each country. Let's take some examples when we use the same visual "logo" we enact a common visual culture. When we speak together about anxiety without feeling the need of taking a lot of semantic cautions, we enact a common culture. When we refer to the word 'WP2' as evidence, we enact a common culture. So, what are material evidence of this shared culture? What is the evidence of its enactment between the partners? How is it communicated to the locals' contexts? It is performative in regards of the implementing of blended therapies?

What is "culture"?

They are too many definitions of "culture" to try to give a good definition in this report. Previously, we simply define culture as "something the partners have in common when they refer to the project". This definition is adequate to our evaluation perspective. To answer the evaluative question, we have to elucidate this "something". In this report, culture is mainly – according to Geertz (Geertz, 1973) – symbolic and symbols system that we use to communicate or to assess the reality of the world. According to Goodenough (Goodenough, 1957) : "Culture, then, consists of standards for deciding what is, standards for deciding what can be, standards for deciding how one feels about it, standards for deciding what to do about it, and standards for deciding how to go about doing it.".

The projects link together several types of cultures. Obviously, no one is cultureless as his/her members of society and groups (ethnic, class, sociability, …). The project could be seen as an intercultural process through cultural backgrounds of the partners, sub-partners and all the stakeholders that could be interested in the project.

The main fact is that interculturality about mental health, anxiety, blended therapies, … seems not to be a main objective of the project. The

way the partner builds a common or a shared culture is merely a tool that must facilitate the work and the reaching of the goal.

A part of this intercultural process is provided by the WP Management. Some activities of team building are, in fact, actions that facilitate the building of a shared culture. These activities begun in the Amsterdam kick-off workgroups, it continued in the Steering Committee. Parts of this process are also visible in each WP goal. The activities and productions provide a lot of symbolics supports for a shared culture. Lastly, the interactions – whatever the media - between the partners are opportunities to perform interculturality. When partners discuss – voices, writing – they have to adjust each other and find the culture of reference. What do we mean by? In my country anxiety is…? I believe we decided users were…? In the following, we discuss some topics about this shared culture.

A culture centred on "academical medical" knowledge ?

Observing the difficulties of the start-ups to fulfil the selection and implementation process, we ask if these difficulties could be related to the meeting of cultures. The supporting process has been conceived as a medical and economic validation of devices. When the start-ups entered the project, they hope to put their device onto the market. The project gathers partners that are mainly cure/care organisations and professionals in the field of psychiatry. These organisations and professionals share a common culture about medicine, quality, validation, ethics, and research. This culture mainly refers to a high-level scientific standard. So, we could say that the project instal high standard medical process to support the start-ups. One question is to observe how this "medical culture" interacts with the more commercial culture of the start-ups.

Technological innovation and social innovation

The project is written in a "form". If the form constrains the flow and the productions of the project and of each WP, it seems to have a lesser

constrain about the meaning of the project. The analysis of the evaluative questions construction clearly shows trends and consensus about the meaning of the project. The meaning is embedded in the perceptions of the stakes and of the finalities.

In fact, IT4anxiety is a social innovation project. The project aims to lead to cultural changes among the professional's practices about the use of technologies in psychiatry. And so, it meets the goals of the Interreg program. "Novel approaches (products, services or models) that meet social needs related to the large societal challenges such as demographic change, migration and climate change in cities and regions of the EU and are being created and implemented not in a traditional for-profit setting but in collaborations and networks of the public, private and third sector and – more and more often – citizens and users of services[2]."

Social innovation is mentioned about the co-construction of the tools and the development of a training platform. In a local steering committee, the staff of "Région Wallonne" (Walloon Region) qualify the project as a "social innovation" process. Last months, co-creation was firmly reaffirmed as an important value in the project in the steering committee. The project must face the risk that social innovation could be hidden by the technological innovation that are very easy to explain and valorise. The question could be: if we speak about IT4anxiety, will we say that it is a project for developing technologies by co-construction or that it is a coconstruction to support IT solution for psychiatry?

We can postulate that the launching of the project was mainly "technical". Such a complex project needs time to start and set all the organisational structure, Committee, tools that will be the basement of the work. In this period, partners are taken by the strategical activities in the flow of the project: organise the communication and the first hackathon, collect the needs, include Start-ups, …

After this launching period, the project is marked by a change in the management. This change was the opportunity for a critical glance upon the project, the WP and the productions. Apart from the management of the timing and the task, the glance enlightens the importance of the co-creation

in the project. Co-creation is not only a process with the users, but also the methodology in the project to support start-ups in developing tools that are truly grounded in needs of the users, legitimised by the quality process and therefore possibly admissible in the contexts of health care and, maybe, in public's health policies. The project is thus a social innovation process because his capacity, despite some difficulties, to make public, private and third sector working together.

The planning of the project is also a factor that at mid-term the project has not completely implemented the main activities about social innovation, mainly the WP3 that provides a training to impact professional culture.

Speech community

We borrow this concept form the socio-linguist (Gumperz, 2009). A speech community regroup persons who share common and sufficient "verbal repertoire" to communicate with each other without too much misunderstanding. The project gathers professionals and non-professionals from different fields of activities and countries. The common language is English. To achieve the goals of the project, the partners must have a sufficient "verbal repertoire" that stabilised the meaning of words. As usual, the language in the form is somewhat consensual, for example as we discuss it about the word "users". But this consensual language will not be sufficient when the partners must concretely operate the activities in the projects. Before the mid-term evaluation, we see a lot of discussions where the partners must reframe the words. In the limits of our gathered information, we identify some topics that frequently need a reframing. In each WP's discussions we accessed, the meaning of the following words has to be negotiated and momently stabilised.

Since the start of the project, there has been a lot of negotiations about the meaning of anxiety and about the targeted publics, the users. The form precises that the target is people suffering from anxiety because of Alzheimer or post-traumatic stress disorder. These negotiations were already observable during the kick-off in Amsterdam. Who are they in the social

world? Who is named? The interactions between partners gone over social characteristics of the users. Without a more accurate definition, it seemed impossible to make some of the activities. Are they young or old? Male or female? What is the severity of the troubles? Are the professional or the families also users?

Anxiety is not defined in the form. It mentions anxiety as a symptom, a consequence of Alzheimer and PTSD. Anxiety was linked to socioeconomical and epidemiological analysis and treatments effects. "Anxiety" was an effective way to precise the goals of the project and to articulate the works packaging, especially the WP1, WP2 and the WP COM. There is no clinical reference, no reference to DSM or CIM.

At first glance, this lack of definition could wear future operational difficulties in the activities. In fact, it was a great opportunity for the project regarding the context of COVID crisis. It was also an opening field to allow negotiations and interculturality between the partners.

The force of this project is to maintain local, professionals, organisational,… culture in contacts by a commitment of partners in each WP. The frequent contacts between partners lead to a more common "verbal repertoire". The management of the project, but also the implications of the partner, allow the emergence of an intercultural process. This process led to an enhanced speech community based on negotiated "verbal repertoire".All the "verbal repertoire" is not in the interactions. The project fixes goals and WP promotes/tests tools that could be seen as formalised "verbal repertoire". The partners pay attention to the stakes of the stigmatisation in mental health. It's not so easy to choose the right words to express or to speak about persons with lived experience of mental health problem. The attention to stigmatisation risks takes part in the quality process of the project. It would be very annoying to promote co-construction and not to manage the risk of stigmatisation. The partners refer to a guideline: "Recommended vocabulary in the field of Mental Health". WP2 is very concerned by formalised "verbal repertoire". The assessment of the tools provided by the start-ups is based on well-defined and understandable criteria by the evaluator. The Indepth filter includes both methods "Scorecard valuation" and "Risk factor

summation". The WP is very precautious about the two methods. Many guidelines and documents are accessible for the evaluators. The MAST (Model for Assessment of Telemedecine) belongs to this category of formalised "verbal repertoire". The MAST, even if the use needs a good understanding of the criteria between the evaluators, sets a common way to assess the tools provided by the start-ups. The WP2 provides guidelines to ensure comprehension of the MAST.

The WP1 inquiry organisation is a case of passages between several "verbal repertoire" in an intercultural context. The inquiry must document the social representations, the needs and the uses of digital technologies for persons who suffering from anxiety.

Alliance

The shared culture is related to the alliance for long-term actions about e-mental health. Stakeholders and concerned public must have the possibility to join the project or federate with the interests at stake as they are identified in the WP LT. Maybe the "culture" mobilised by the partners is a part of the attractivity for the dissemination of e-mental health. Currently, it's hard to evaluate if the project allows the construction of an alliance. They are few data that could be interpreted that way. The followers on the social media participated to this but social media around IT4Anxiety does not seem to be a community of interest prone to get into action in favour of supporting the implementation of e-mental health. In Wallonia, the project seems to become more notorious, as people speak about it and manifest interest about the financial and methodological support in developing e-mental health.

How does ethics play and act in the project?

What is ethics? In the project, ethics is assumed by an ethics committee and by the respect of ethical norms for the research and tests in the field of health. But ethics could also be seen as a criterion for all the actions of the project. It could very innovative if the project places ethical

concerns in all its actions, and even more if the project manages to identify an ethical guideline and an ethical posture in relation to the uses of blended therapies for anxiety and maybe for the uses of digitalization in mental health. The project has rapidly set-up an ethics committee, that is ruled by an ethical guideline (Genard & i Escoda, 2019). From the beginning, the observations data's show that ethic is nodal in the process of the project. In the project, we can see two faces of ethics. One face could be named "procedural ethics" and the other face "situational ethic". The procedural ethics is the work accomplished by the ethics committee to validate the production and maintain high ethical concern in the project. This procedural ethics is concerned by informed consent, Nuremberg code, professionals' relations. The procedural ethics is mainly medical ethics, research ethics and commercial ethics. The "situational ethics", but maybe the label "moral" could be better, includes all the moral debate in the project. Partners have sometimes such debates about the technologies, the social effects of the technologies, the stigmatisations and the identity of the users, social iniquities, … As example of debate, the plus-value of e-mental health device is well accepted among the partners, but some partners feel the need to frame the conditions of the use and dissemination. A Partner said, "we cannot create the need", meaning that the existence of emental health device could not lead the creation of a bad use or induce trouble feeling among population that lead to self-medicine. This kind of regulation are less observed in the meetings than referential or vocabulary adjustment.

How to link the actions between the different work packages?

In fact, the project is structured around work packages. This structure is useful for writing the project and estimate the workload of the partners. On the contrary, the work packages are not truly the project itself. In terms of evaluation, the project is easier to understand from its "theory of action". To achieve the main goal of the project, the actions and the work packages are organised in a form of causality. For example, we can implement and make advocacy for blended theories if … Generally, the theory of action

implies a networking organisation between the work package. The theory of action is a theorical framework for the project. It cannot foresee all the practices events that the partners will have to overcome together. It's a matter of sharing resources, contacts, competencies, knowledge, times, lessons from the field.

The project rationale is built around three functional WPs (WP1 'needs', WP2 'Hackathon and validation', WP3 'Training'). These three WPs are supported by two strategic WPs (WP COM 'communication, WP Management). A WP LT is orienting the project towards the future. However, the realisation of the activities of each WP makes it necessary to have an entanglement between the partners. The partners are both responsible for a WP but involved in the activities of the other WPs, as in most European projects. The organisational logic is "everyone involved in everything". This gives a potentially dense network of relationships. The idea of the project is to rely on the organisation of a collective intelligence where knowledge and skills are exchanged and complement each other to achieve the objectives. This entanglement through activities has had a positive effect on the meetings and exchanges between the partners, and therefore on the negotiation of the frameworks of the action: which meanings, which means, which methods, ... the success of this entanglement and the supports it generates between the partners has woven social relationships (work, but also conviviality) between the people. The observations and informal exchanges testify to the social relations between the people involved in the project.

On the other hand, this interweaving, which is the bearer of coherence, has also been questioned about its efficiency by the partners themselves and by the regulation of the project. The multiplication of meetings, the requests for re-reading or co-construction generated an overload of work compared to the projections made in the project. At the same time as it strengthened cohesion through the exchange of points of view, it would seem that the WPs became more difficult to manage, particularly in terms of decision-making and process. It also makes justifications in timesheets more complex as relational processes and

interactions are not easy to quantify. Who would think of noting the 15 minutes with such and such a person, the 10 minutes to write such and such an email, etc.? The handover of the project management was an opportunity to take a step back from the time-consuming and energyconsuming effects of this integration. A new look at the way things were working, which had then become normal, enabled the structural framework of the project and its objectives to be restructured.

How are the start-ups supported with their innovative solutions through the whole process (co-creation, testing, validation) until entering the market?

This question was suggested by a partner and indeed was also at stake when the discussions are about the start-ups. IT4anxiety joins several worlds with their own vison and norms. The project could be seen as a mediation process between the medical world and the start-ups world. This question relies to social innovation. The configuration of the stakeholders is very heterogeneous. The process of selection, validation, supporting and valuing of the start-ups is rational and streamlined as it was described in the project. However, apart from the delays due to the pandemic, this process is facing concrete difficulties, some of which were anticipated in the project risk analysis, such as financial risk management. Other obstacles were encountered during the implementation of the project. In their quality management, the partners identified these obstacles. The first obstacle was identified at the time of the meeting between the world of start-ups, researchers and medical ethics. The selection process for start-ups includes evaluation stages whose criteria and expectations seem to have surprised the start-ups.

The development of an IT product is much more complicated in the field of medicine and psychiatry. A second obstacle emerges from this process: the devices must be tested, the test must be researched and the research results must be published. The standards are different between the testing of the device and their scientific valorisation. It is important to understand that the project organises support for start-ups to develop and

valorise their products. This process can be seen as an intercultural mediation between different worlds and cultures. It is not a validation of the start-ups' products. In this sense, IT4Anxiety's role is not to regulate the entry of these products onto the market on the basis of tests carried out within the framework of the product.

These two obstacles call into question the possibilities of commitment of start-ups and show the difficulty of synchronising the time of development and the time of scientific and ethical validation. Some of these issues are analysed in the guide de la Haute Autorité en Santé (guide from the French National Authority for Health - HAS – only available in French): "This reference framework of good practices, which is intended for manufacturers and evaluators (evaluation structures, consumer associations or medical learned societies), aims to guide, promote the use of and strengthen confidence in applications and connected objects[1]. How can we better understand the logic of start-ups and integrate it into the project's functioning? What are the economic and social issues surrounding the process of supporting start-ups? What are the expectations of public authorities as far as the development of e-mental health is concerned?

This question of support for start-ups is also a question of how the support and meetings with start-ups enable the other partners to appropriate or update their knowledge and practices concerning e-mental health, technological development and related technical knowledge? It sets the framework for defining what could be considered innovative in a world where innovation, or even disruption or rupture, is a strong development value.

This is the most critical issue in relation to the project objectives. The project aims to select 15 start-ups, test and validate their products and ensure publication of articles in a co-creation process.

At the scale of the project, this process has not been able to acquire the maturity that it could have acquired following the regulation operations through the organisation of hackathons; the organisations of the latter having been very much impacted by the pandemic. In an early phase of the project, it seems that the support process was absorbed by meeting deadlines

and the challenge of including start-ups, perhaps at any cost, to meet the objectives. The process could not be finetuned before the first Amsterdam hackathon was organised.

The selection process is an evaluation which, from a methodological point of view, takes all the necessary precautions for the construction of an expert judgement on the start-ups' products: explicit procedures and criteria, training and regulation of the evaluators, precise and personalised feedback to the start-ups.

From a retrospective point of view, the adhesion and support of the start-ups is an issue that was already present at the time of the project launch. During the preparation of the project (meeting in Namur), a representative of a start-up had raised the risks he perceived in relation to the process. The start-up had already incurred expenses for the development of its product and it expected the project to support the validation of its product for the purposes of commercialisation, return on investment and sustainability. The discussion that followed focused on the timeframe of the product support and validation process. Would this process be fast enough? Was it worth the time the start-up would have to invest in it?

The entry of the first start-ups into the project is helped by strong networking by the partners who are already in contact with these start-ups. The first start-ups embark on the project with the partners, mainly French and Dutch. Other start-ups are identified and recruited at the time of the hackathons or brought in by the partners along the way. The range of technologies presented by the start-ups involved at the beginning of the project is varied in terms of digital technology, which represents an interesting panel of the variety of innovation in e-mental health.

The selection process for start-ups is an assessment of financial risk, maturity and product quality. For start-ups, the selection process consists of submitting a file to the Validation Committee, all in English. It seems that this process is perceived by the start-ups as very complicated and demanding. The files are not easy to complete, and the scientific and medical logic of product evaluation must be understood. The critical variable in this process is mainly time, i.e., the deadlines for decision-making and the

synchronisation of the project's temporality (e.g., financial reporting) with the start-ups' deadlines. The selection process is caught up in complicated issues. It is a question of building the value of the product by respecting quality criteria through a co-creation process, but whose ownership thresholds do not seem to facilitate the adhesion of start-ups. The latter may in turn have difficulty in understanding why what seems to be self-evident in product development becomes so complicated in the field of psychiatry. The difficulties encountered by the start-ups could hinder their adherence to the project and thus the achievement of the announced objectives, which puts a strong pressure on all the processes that involve the start-ups, with sometimes the impression that they have committed themselves "without knowing what to expect" in terms of steps and deadlines.

How could this process be made easier for start-ups while not sacrificing the product validation or co-creation process? Support, through the network of partners, facilitates the testing phase. Partners from care institutions are in a position to provide access to psychiatric services for the testing of devices. The test phase is also facilitated at the level of the ethical committees by the work done upstream during the selection process. Access to the test sites required more negotiation than expected and more precautions due to the pandemic. The project needs the relationships between the partners and the health care institutions to play this facilitating role. Perhaps one of the difficulties less anticipated in relation with testing was the reception of the entry of digital technologies into the field of psychiatric care? If e-mental health and its added value federate the partners, perhaps it is not obviously desirable for other actors. This leads to time consuming negotiation processes with the test sites, as the test sites have their own meeting agenda and decision-making.

However, the testing moment is essential in the co-creation process. It certainly allows for a test in a real situation, but above all it constitutes a moment of encounter with users, patients and professionals, and is one of the levers for participation.

Start-ups in the test phase do not seem to be equipped to carry out a test based on a scientific protocol. This is also a point of hiatus between a

development culture and a scientific culture that do not operate according to the same standards. It is therefore necessary to find internal resources to help start-ups achieve a higher standard of quality in testing. Similarly, it appears that start-ups will need more support to be able to publish test results in scientific journals, although the level of targeted journals is not decided. As a next step, and in line with the announced deliverables, it would be necessary to provide more support to start-ups (some start-ups) for tasks that require the expertise of researchers.

The adhesion and recruitment of the start-ups is partly linked to an event that animated the exchanges between the partners about the WP1 place. This event shared the organisation of the process between two visions of the project's development. In a vision rather inspired by the idea of production line or project cycle, it seemed that WP1 had to provide from the beginning of the project objective elements about the users' needs, needs that should also be used as a basis for the hackathon and thus for the selection of start-ups. This vision was in competition with the scientific logic of the survey conducted in WP1, which was not connected to the process of supporting the start-ups. If we go back to the definition of culture, the evaluation documents the lack of knowledge of start-ups to understand and act in relation to the "medical" culture and its norms and standards.

Discussion

Mid-term stakes for the project

The project is a dynamic between the partners who work together to implement the objectives. This dynamic is structurally supported by the work of the WP management, but also by the involvement of the partners. However, this dynamic is not always effective. Constraints linked to local organisational realities are obstacles to this dynamic (authorisation, administration, changes in the teams, etc.). On the basis of this dynamic, which was able to be created and maintained in a period of lockdown that

was not very conducive to meetings between partners, the initial results of this evaluation identify the following issues:

- Maintain the interactions between the partners as these interactions:
  - involve learning about each other's constraints and contexts,
  - facilitate the helping hands between the partners (exchange of knowledge, know-how)
  - implicitly develop anchor points for a common culture
- Enhance the level of user participation, where it is possible, for example in hackathons or in the steering committees.
- Improve the accompaniment of start-ups in the project (explanations of expectations, educational and technical support)
- Inscribe the project in local and regional contexts
- Make the WP Long term a discussion topic between the partners as a lever to work on the vision and the meaning of the project
- Make a vision shift from "technological evaluation" to "social innovation".

Regarding these advises, some of them truly impact the following of the project. The partners were more aware about the participation of the patients. This awareness had two sides. The one side was to collect more accurately the information about participation. The second side put participation as a quality criteria of the action. The accompaniment of the start-ups was changed to facilitate their involvement in the project. The new accompaniment facilitated the writing of ethical consent, the relation with the testing sites (hospital) and monthly meetings were set. The accompaniment became thus more friendly to the start-ups and their capacities. They became more supported and felt less judges by medical norms that they didn't understand. The main change concern the vision of the project. We decided to focus the final evaluation on the question of the social innovation. In fact, social innovation was announced in the form but it has been drowned in the realisation of the activities, as the WP Long term was not sufficiently take in account by the partners. This evaluative process, *in itinere*, has flexed some part of the project. This flexion was chosen by the

partners in accordance to the social stakes that underlay the e-mental health (Briffault, 2019).

The evaluation is a collective learning process

This evaluative analysis borrow from different evaluation theories which are all more concerned by the meaning of the project than by the measurement of the objectives fulfilment. A same epistemology, the constructivism, gathers these theories (Conan, 1998). The classical evaluation, by the objective, does not take in account all the versions of the project. It only take in account the results that match with the objective. But the project is more than the objectives as they were written in the submission form. The project also exist in the real work done by the partners in interaction, by the practical way they resolve difficulties, uncertainty and give meaning to the objective of the project. The written objectives get meaning in the real action where their logic and their consistency are submit to the prove of the action.

For this kind of evaluation the reality of the project is also the way it is seen and thought by the partners. In fact, the project exist in many versions that are made for practical purpose. The practical purpose of this evaluative analysis is to nourish and sustain the project itself.

This kind of evaluation is not an easy way. Despite the methodology guides and despite theory, this kind of evaluation still very marginal. In a dominant culture of managerial evaluations, constructivist evaluations seem strange to the people (Baron & Monnier, 2003). It take a long time for the evaluator in IT4Anxiety to negotiate the interest of this approach with the partners but also with the management. Because the process needs the true participation, this evaluation cost a lot of worktime for the partners. This cost was a difficulty to get a maximum participation of all the partners until they were encourage to participate by the project leader and until they see more clearly the utility. The solution to this problem is simple : such evaluation must be inscribed in the project as an action so the partners could easily declare their participation as working time.

As an ongoing process of discussions, this evaluation is quite sensible to linguistic problems and misunderstandings. The English was the language for most of the meeting and documents. The partners form France, Belgium, Germany and Netherland were not native speakers. Foremost, the mastering of the language was different among the partners. It takes times and many precautions to get an accord upon the wording of the evaluative questions, criteria and indicator. The use of the English for the evaluation was an obstacle for the participation of the patients association to the evaluation. We must have to forecast more translation to support the participation process.

Conclusion

At the beginning of the project, the evaluation data tend to show that the project was mostly managed and arranged in an internal perspective. The social environment of the e-mental health was mainly perceived by the intersubjectivity of the partners, who are experts in psychiatry, mental health, digitalisation, and business models. The users were not sufficiency present and their participation was low. They exist through literature analysis and expertise of the partners. As the project is a very intense network of relations, at the beginning and because of the energy needed to launch this complex project, e-mental was not sufficiently framed by taking into account the variety values about e-mental health. The e-mental health and the need for it seemed taking for granted and maybe the stakes of WP LT not so much important. Meanwhile WP LT clearly expresses the stakes of the future of e-mental health.

This evaluative process is fruitful for its multiple purpose. Because the partners were involve in the constructing of the evaluation, they build a common vision of the meaning of the project. Thus this evaluation is qualitative and is founded upon observation. We haven't measurement for our statement but the true validity of these is the intersubjectivity between the partners. This kind of participative and negotiated evaluation provide insights to regulate

the project, mainly it provide and alert about the user's participation and about the support offer to the start-ups. Sometimes evaluation process put some implicit dimension of a project into light. In the case of IT4anxiety, the evaluation lights the fundamental difference between technological innovation and social innovation. As the evaluation aims to add value to the project, IT4anxiety could be seen as a social innovative project. It's very important because mental health should not become a field for only commercialisation of the digital tool base on the evidence of technological progress.

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Annexes

Q1. How high is the user's participation in the project?	
Criteria	Indicators
1.1 The people suffering from anxiety (illness/sickness/ disease) have the higher level of participation on the Arnstein scale	1.1.a The people suffering from anxiety take decisions in the project
	1.1.b The people suffering from anxiety are associated to the actions in the work packages
	1.1.c The people suffering from anxiety are consulted about their needs
	1.1.d The associations, federation, Ligue of users are partners of the project
	1.1.e The associations, federation, Ligue take decision in the project
	1.1.f The project translates some documents for the people suffering from anxiety
	1.1.g People suffering from anxiety and associations have learned about E-mental health stakes
	1.1.h The voices of the people suffering anxiety is audible in the project
	1.1.i The people suffering from anxiety are not reduced to their illness
1.2 Person who cares and lives with people suffering from anxiety have at least a citizen participation	1.2.a Care givers take decisions in the project 1.2.b Care givers are associated to the actions in the work packages 1.2.c Care givers are consulted about their needs 1.2.d The associations, federation, Ligue of people are partners of the project 1.2.e The associations, federation, Ligue take decision in the project 1.2.f The project translates some documents for the care givers 1.2.g People suffering anxiety and associations have learned about Emental health stakes 1.2.h The voices of the care givers are audible in the project
1.3 Professionals of mental health care participate at least as much as citizens	1.3.a Professionals take decisions in the project 1.3.b Professionals are associated to the actions in the work packages 1.3.c Professionals are consulted about their needs 1.3.d The associations, federation, Ligue of professionals are partners of the project 1.3.e The associations, federation, Ligue of professionals could take decision in the project 1.3.f The project translates some documents for the Professionals 1.3.g Professionals and associations have learned about E-mental health stakes 1.3.h The voices of the care givers are audible in the project

Q1. How high is the user's participation in the project?	
Criteria	Indicators
1.4 Professionals of the start-ups participate at least at citizen level	1.4..a Professionals take decisions in the project 1.4..b Professionals are associated to the actions in the work packages 1.4..c Professionals consulted about their needs 1.4..d Professionals and associations have learned about E-mental health stakes 1.4..e The voices of the start-ups givers are audible in the project
1.5 All the partners participate in the project	1.5.a Partners are consulted and give their advice 1.5.b Partners have locations and process to support their participation 1.5.c Partners give advice to other partners

Q2. How does the project manage to build an alliance for the promotion and the implementation of e-mental health? How does the project construct a shared culture about e-mental health between the partners?		
2.1 IT4 anxiety can recruit, associate new stakeholders in a variety of fields	2.1.a 2.1.b 2.1.c	Stakeholders are interested in the project New stakeholders join the project The projects allies belong to all strata of the society
2.2 Partners or sub partners diffuse the project	2.2.a 2.2.b 2.2.c	They represent the projects during events They promote the project on social media They build network in relevant communities and generate interest for the project
2.3 IT4anxiety provides support to advocacy about e-mental health	2.3.a 2.3.b	Existence of written support, multimedia Argument on the risks/benefits of e-mental health
2.4 The partnership could last after the project	2.4.a 2.4.b 2.4.c 2.4.d 2.4.e 2.4.f	Partners are thinking about a project for the future Partners want to continue collaborations The partners decided to continue the collaboration The project's productions are still searchable and broadcasted Partners enjoying working together What the partners learned about other countries/regions could be transferred in future European projects
2.5 The project has a proper visual identity	2.5.a 2.5.b	The project is visible in the field of e-mental Health Pictures truly tell the story
2.6. The partners have built a common vision about	2.6.a 2.6.b 2.6.c	The vision is discussed The vision is implicitly present The vision is explicitly present

Q2. How does the project manage to build an alliance for the promotion and the implementation of e-mental health? How does the project construct a shared culture about e-mental health between the partners?		
e-mental health and blended therapies	2.6.d	The medical basis culture could be a difficulty for some stakeholders
2.7. The partners manage to compose with the definition of "anxiety"/PTSD	2.7.a 2.7.b 2.7.c	Partners explain their definitions of anxiety/PTSD Partners reach practical agreement on defining anxiety/PTSD Partners overcome differences to set the actions
2.8. The partners have some values in common	2.8.a	Decision process is also led by an explicit set of values
2.9. The partners use a common vocabulary about e-mental health	2.9.a 2.9.b 2.9.c	There is a reference vocabulary The reference vocabulary is used by partners Partners create a reference vocabulary that reflects project values or their own values
2.10. The objectives of the project are well known by the partners	2.10.a Partners refer to the project's objectives 2.10.b Partners agree on the meaning of the project's objectives 2.10.c Partners take ownership of the project's objectives 2.10.d Partners innovate in the project	
2.11. The project manages to link transeuropean scale and local scale for the actions	2.11.a Regional adaptations of the process and the production 2.11.b Project adaptation to the regional culture and organization 2.11.c Linkage between the project and the regionals actors	

Q3. How does ethics play and act in the project?		
3.1 The ethics committee is sought and its opinions are communicated	3.1.a 3.1.b 3.1.c 3.1.d	The testing process is validated by ethics committee Internal questions are submitted to the ethics committee The ethical statement of the project is known by all the partners Each partner could ask advice to the ethics committee
3.2 People suffering from anxiety are not stigmatised or labelled	3.2.a 3.2.b 3.2.c 3.2.d	The project paid a high attention to the risk of stigmatisation or labelling for the people suffering anxiety/PTSD A politic against stigmatisation exist in the project All the stakeholder that could be included in the projects (as new start-up or local partners) know this politic In the social interactions with users (patients): what is considered as stigmatisation is let to their own appreciation
3.3 The socio-economic accessibility of the	3.3.a 3.3.b 3.3.c	The project paid attention to the accessibility of the blended therapies The project takes "gender" in account

Q3. How does ethics play and act in the project?		
blended therapies is taking in account	3.3.d	The project takes social iniquities in account The project care about illness and sick role
3.4 Ethical concerns have a role in each work packages	3.4.a 3.4.b 3.4.c 3.4.d	Ethics matter is more important than an unconditional respect of the objectives Informed consent are provided to the users Local ethical committee are committed "Participation" is an ethical issue

Q4. How to link the actions between the different work packages?		
4.1 IT4anxiety has an explicated theory of action	4.1.a 4.1.b	Find the formulation of theory of action into documentation Partners find agreement to achieve the goals
4.2 Partners share resources, whatever their nature	4.2.a 4.2.b 4.2.c 4.2.d 4.2.e	Sharing idea Sharing competencies Sharing contacts Sharing tools Partners learn from each other
4.3 Partners are involved in several work package	4.3a 4.3b 4.3c 4.3d	Meeting and task imply variety of partners in each work package Partners have meetings about network organisation Partners take part to the project management There is an overall responsibility to reaching the project's objectives
4.4 Partners manage to start the project on a solid basis	4.4.a 4.4.b	Partners overcome the complexity of the project The project provides tools to sustain collective work
4.5 The project allows partners form different work cultures and settings to work together	4.5.a 4.5.b	Work package achievements are frequently the result of arrangements/agreement Contacts between partners is an intercultural learning

Q5. How are the start-ups supported with their innovative solutions through the whole process (co-creation, testing, validation) until entering the market?		
5.1 The project facilitates the identification and recruitment of start-ups that propose high quality or potential high quality blended therapy	5.1.a 5.1.b 5.1.c	The project is in contact with Start-ups The project manages to select high quality start-ups and products The project attracts other developers that are not start-ups (university, public organisations, …)

Q5. How are the start-ups supported with their innovative solutions through the whole process (co-creation, testing, validation) until entering the market?		
5.2 The start-ups included in the project are satisfied with the support	5.2.a 5.2.b 5.2.c 5.2.d 5.2.e 5.2.f 5.2.g	The start-ups identify the facilitations offered by the project The start-ups have no complaints about the project The process could disengage start-up Start-ups discover unexpected difficulties in the process The process is financially secure for the start-up English is a difficulty for French, German, Belgian, Luxembourg start-ups Temporality of the start-ups and their financial model are taken into account
5.3 The support process to improve the quality of the products	5.3.a 5.3.b 5.3.c	The start-ups take the needs into account to develop their products Selected start-ups are sensibilized to the risk of stigmatisation and labelling The process allows meeting between start-up and users
5.4 Start-ups understand the procedures for entering the medical market	5.4.a 5.4.b 5.4.c	Recommendations for start-up are understandable and easy to apply Start-ups have taken the test of their product Start-up receive support to set the testing protocol

Impact of Social Policies on Community Services

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Abstract: This material refers to social policies in general and how they have been related to the needs of vulnerable groups, as well as to the analysis of social policies at the time of Romania's pre- and post-accession to the European Union, marking the reforms in the field of social services and the development of the social assistance system. Another approach will summaries the European objectives for the social sector and how they have been and are being transposed, planned and implemented through national strategies and the impact they have on vulnerable groups at local level. It will refer to the dynamics of vulnerable groups in the municipality of Arad starting from the strategic programming periods, so the study will focus on groups at high risk of social exclusion in the municipality, which are represented by: young people leaving the social protection system, disorganized families, elderly people, people with disabilities, victims of domestic violence, homeless people, as well as an important part of the Roma population. Unified and clear lines of action, based on sound social policies, based on the real needs of a society lead to the achievement of objectives and results with a positive impact on vulnerable groups. In this respect, the last part will focus on the existing local social assistance system, the types of beneficiaries and the needs for organizational development.

CHAPTER I: Social Policies and European Strategies in a National Context

With the first European social model found in the Treaty of Rome, the first Community documents also appear, which focus on social policy at

a planned level and create a systematic approach to social problems and risks with the emphasis on resolving them through a system of social protection, social solidarity, and economic progress, fighting to guarantee human rights and freedoms. (Pascariu, Sandu and Ianos, 1997; Kok, 2003).

The starting point of the Amsterdam Treaty concluded in 1997, which insisted on the transformation of social and employment policies into common policies for the Member States of the European Union, was a key stage in the development of social policy, marked by the document launched in 2000, the Lisbon Strategy, which set long-term objectives based on a thorough knowledge of the situation in the Member States, objectives which would be translated in the same year into a short-term action plan adopted as the Social Policy Agenda. This focuses social policies on quality and social cohesion with an emphasis on competitiveness and quality of work, linking economic and employment policies. For social policies to work, tools and methods have to be developed to implement them. Thus, in 1997, the first European strategy was adopted, the European Employment Strategy, which was designed as a guiding and coordinating instrument for the Member States. Although it does not lay down specific guidelines for social assistance, it does highlight issues of equal opportunities and protection against discrimination, which helps women and people with disabilities. In the light of developments in social policies, we note the emergence of European financial instruments, namely the European Social Fund and the Progress Programme, which support the implementation of the European Employment Strategy with three key actions aimed at training and retraining and actions aimed at creating new jobs. At the same time, the financial instruments ensure support for the modernization of social protection through adaptation to quality standards and social inclusion. We cannot overlook the European Social Charter and the value attributed to the social system when it came into force in 1998, which establishes and guarantees human rights and freedoms and was the basis for the 2005 National Strategy for the Development of Social Services. (Chasard and Preda, 2000; Naumescu, 2003; Vătman and David, 2008; Law 74/1999).

The implementation of the Lisbon Strategy by 2009 promotes competitiveness and dynamics based exclusively on knowledge in all its segments. It can be seen that it sets a clear objective for the social sector towards which Member States should aim, namely the modernization of the European social system through two main directions: investing in human resources and promoting social inclusion. The Europe 2020 strategy comes with a new economic vision to help the EU emerge from the crisis by promoting a smart, sustainable, and inclusive economy through employment, productivity, and social cohesion measures. Structured around three interlinked and mutually reinforcing thematic priorities, smart, sustainable, and inclusive growth is based on targets to increase the number of people in employment, increase investment in research and development, reduce early school leaving, and reduce the number of people at risk of poverty. Each Member State adapts the Europe 2020 Strategy to its specific situation, and it is an essential benchmark in the development of national strategies. (Bărbulescu, 2011; Profiroiu, Profiroiu and Popescu, 2008).

Tracing the evolution of the social assistance system at the national level, we can identify some key aspects that it has followed. Thus, it can be seen that the post-December period is characterized by the provision of "emergency" social services without focusing on solving the causes of social problems but on the system of social benefits, all centrally organized. The next four years are marked by the beginning of decentralization and the transfer of responsibility from the central to the local level, a process that continued until 2003, when the national control and monitoring bodies in the field of social assistance were created. The first legislative regulations on the protection and promotion of children's rights, the national social assistance system, and the first National Strategy for the Development of Social Services with an action plan for the period 2006–2013 appear. The provisions that this strategy brings to the public sector at the local authority level include clarifications regarding the organization and provision of social services as well as recommendations for the development of public-private partnerships and inter-institutional relations. It is highlighted that institutional development at the local authority level becomes a strategic

objective, and the key words leading to its achievement can be summarized and named by the four R's: redefinition, review, resources, and accountability. The working, organizational, and planning tools are now being defined, and the need for specialized human resources is being emphasized, as is the need for community development in view of the financial mechanisms launched during this period. It should be recalled that the strategic planning period is complementary to the National Development Plan and the National Strategic Reference Framework 2007–2013 documents, which were developed in line with the EU Cohesion Policy and promise a phased financial package with a major impact on socio-economic development at the local level. Thus, funding opportunities in the field of social services lead to key directions: development of human capital, promotion of social inclusion, and improvement of social infrastructure (Law 705/2001; GD 1826/2005; Law 47/2006).

The next strategic programming period for social assistance 2014–2020 is based on the Europe 2020 Strategy and is reflected in the six national sectoral strategies, which aim to promote children's rights, promote active aging and protection of the elderly, create a barrier-free society for people with disabilities, include Romanian citizens belonging to Roma minorities, promote equal opportunities and treatment between women and men, and combat domestic violence. Thus, Romania sets value targets in the social field, including the employment rate assumed by Romania, which must reach 70% for the age group 20-64 by 2020, social inclusion and poverty reduction, which aims to reduce the number of people at risk of poverty and social exclusion by 580.000 people by 2020 through measures aimed at reviewing and implementing the social assistance program so as to guarantee a minimum income to all citizens, targeted support for the poorest families, development of social services aimed at improving the quality of life of people belonging to vulnerable groups, creation of the appropriate framework to facilitate access and participation of vulnerable groups in the labor market, development and improvement of social infrastructure, improvement of access to health services for people belonging to vulnerable

groups (GD 1.113/2014; HG 383/2015; HG 566/2015; HG 655/2016; HG 365/2018; HG 18/ 2015; HG 383/2015).

Under the County Social Services Development Strategy, local public authorities have responsibilities both in establishing social assistance entitlements and in providing financial support for services. At the same time, the role of local councils in the development of social assistance activities at the community level is strengthened by organizing and supporting social assistance activities at the local level. The strategic measures established at national level focused on an integrated approach to inclusion policies in order to increase access to employment as well as to ensure social protection and access to essential social services, lead to the intensification of social assistance activity but also to the development of the Public Social Assistance Service, thus through the legislative changes that have occurred in the provision of social benefits - the main activity is focused on: granting of social aid, granting of food at the social canteen, granting of emergency aid, granting of allowance for newborns, granting of salaries for personal assistants of severely disabled persons, granting of allowances for severely disabled persons, granting of free public transport for severely disabled persons and their personal assistants, for severely disabled persons and for blind persons and their companions, granting of cash aid for home heating (HG 797/2017; HCJ Arad 309/2013).

Taking into account the strategic directions outlined at European level, social policies in Romania in the fields of social assistance and family policies are developed in three subdomains: social benefits and services, protection of the elderly, and social exclusion. Starting from the restorative stage in 1990, social assistance in the municipality of Arad was limited to the social services organized under the Administrative Territorial Unit of Arad. Towards the end of the year, however, following legislative changes in the institutional organization, departments were created under the social service organization, such as the care of minors, the social canteen for people with no or low income, and the night shelter with day center for homeless people. At the end of 1993, the social hostel was set up following the identification of this need at the community level. After the age of 18, young people from

institutions that were part of the child protection network no longer benefited from protection, being considered adults according to the legislation in force, so this service provided temporary accommodation and helped with their social integration. We note that in 1998, a pilot center was set up for HIV-positive children to provide them with therapeutic and educational services. Analyzing the strategic programming periods and the financial instruments that support the social system in order to complete the deficient social net, at the level of Arad municipality, the public social assistance service develops on the palette of primary social services with the aim of preventing institutionalization both in terms of the child at risk and in terms of the elderly and disabled. Thus, a network of day centers for children with a counseling component for parents and a network of day centers for the elderly with a rehabilitation and medical monitoring component are being developed. In the context of the implementation of the social inclusion objective, in 2003, the public social assistance service of Arad started the implementation of a project with external non-reimbursable funding for children from disadvantaged social backgrounds, especially Roma children, with the aim of preventing school dropout and promoting intercultural education. The residential care center for the elderly, which is intended for people who are partially or totally dependent and who are unable to carry out their daily activities on their own, is also being reorganized under the public social assistance service. Last but not least, the department for the protection of people with disabilities is also organized, which later adapts to the directions set by the sectoral strategies and channels its attention towards two other important segments, namely home care and community health care (Law 17/2000; HCLM 50/2003; HCLM 409/2004).

Among the problems identified at the level of Arad municipality in the period 2003–2005, the lack of housing for members of the Roma community was highlighted; thus, through a Phare project, social housing was built for this group of beneficiaries, and through the financing mechanisms managed by the Romanian Fund for Social Development, a complementary project was implemented through which the integration of young beneficiaries into the labor market was achieved through professional

qualification and accompaniment in order to find a job (HCLM 293/2004; HG 430/2001).

Taking into account the lack of specialized services for people with disabilities and the need to implement programs leading to social integration, equal opportunities, and adaptation from general to specific, in 2008 a strategic project was started to implement two sheltered units whose specialized activity is focused on increasing the degree of independence and integration into the labor market (HCLM 18/2011).

Between 2008 and 2013, an improvement of the social infrastructure is observed, a diversification of social services appears, and attention is focused on the integration of young people from the care system not only at the level of housing but also at the level of social rehabilitation towards an autonomous life where all local actors are involved in order to contribute to solving social problems. During this period, we can see a concrete delimitation of social services focused on primary and specialized services and a qualitative approach to them. In this sense, we find a public social welfare service focused on primary services and social benefits, organized by categories of beneficiaries. If, as far as social benefits are concerned, services are offered as a whole and across the whole segment of beneficiaries, the situation of social services is divided by categories of beneficiaries and departments. The Child and Family Protection Service provides social placement for categories of beneficiaries such as children and young people at social risk, young people with disabilities, deinstitutionalized young people, and children from Roma communities, where intervention is carried out with a family approach. Adult Protection Service with networked day services for the elderly as well as temporary and day accommodation services for the homeless The Disability Protection Service supports people unable to care for themselves or at social risk. We will note that this structure is maintained in the planning period 2013–2020, and the changes that occur are only at the level of departments organized within the services where new tasks appear, but we will develop these aspects in the next subchapter (Strategy DGASPC Arad, 2008; HCLM 373/2009; HCLM 251/2017).

Social Strategies in Community Care

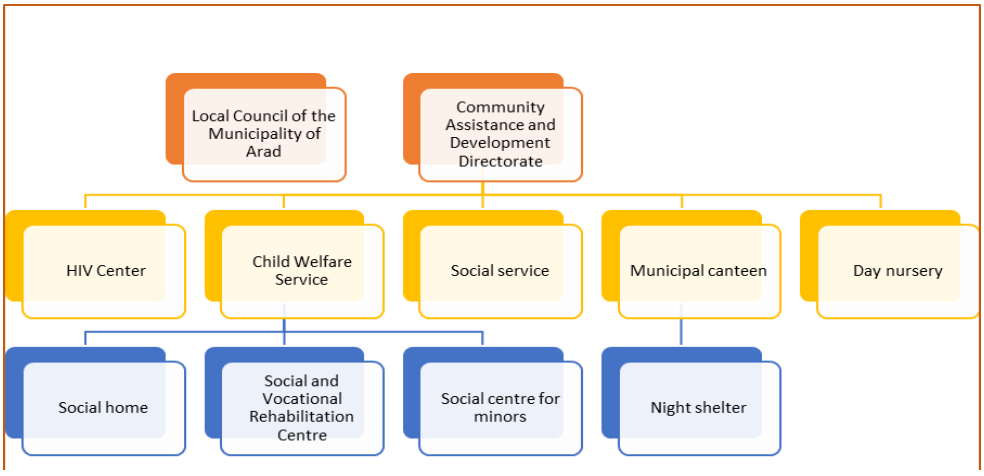
To begin with, a brief analysis of the public service of local interest, Arad Social Welfare Department, will be presented, focusing on three periods that coincided with the establishment of the unit: the first strategic programming on social services, namely 2006–2013, and obviously the programming period that ended, 2014–2020. It will continue with the current structure of social services, which will be detailed in the second part.

In order to provide social services in Arad, in 2001, the City Council approved the establishment of a public service of local interest, which at that time was called the Directorate of Community Development and Assistance, later becoming the Directorate of Social Assistance. With the assumed aim of providing social protection for all categories of beneficiaries in Arad municipality, it can be observed in stages how the institution will develop in this direction, guided by national strategies and specific legislation adapted to community needs (Law 215/2001; HCLM 123/2001; HCLM 249/2017).

From the establishment of the public service to the present day, several essential points have been made in order to adapt to the legislative framework, which, as we know, has brought many tasks and imposed many methodological rules. Thus, the year 2004 is marked by the development of the service on the social benefits side, now being part of the process of classifying the person as disabled, following the takeover by the general directorates for social assistance and child protection of the duties of the state inspectorates for the disabled. The period 2001–2006 is marked by the first national strategy in the field of child protection involving the institution in the process of deinstitutionalization, reintegration and prevention of abandonment, with community social services for child and family protection being developed during this period. With the advent of legislation on the accreditation of social service providers, the public service obtained accreditation in 2007 and three years later obtained quality certification for the management system through the implementation of the ISO:9001 standard (HG 90/2003; HCLM 82/2001).

In the first organizational structure of the public social assistance service in the municipality of Arad, there are social services that functioned at the level of the Territorial Administrative Unit as distinct services, and

here we refer to the Municipal Social Canteen, the HIV Center, the Night Shelter, and the Service for the Protection of Minors with the three subordinate centers: the Social Hostel, Juvenile Reception Center, and Socio-professional Rehabilitation Center. On the other hand, the Social Service administered social benefits, which at the time consisted of state child allowance, financial aid/emergency aid, and social aid/guaranteed minimum income. Also during this period, the six crèches with early education and protection services for children from disadvantaged backgrounds were taken over from Arad County Hospital. The categories of beneficiaries for whom social services or benefits were offered in 2001 were: persons or families at social risk, homeless persons, young people from the care system, and children at risk of abandonment. Although other services were included in the institution's organization chart, they were not functional and had not been established, so we can consider that at that time the organization chart also had a planning and development function. We can understand this in the sense that the grants at that time required beneficiaries to certify the existence of the newly created service on the organization chart at the application stage. From this perspective, Figure 1 represents the graph of the social services existing at the level of the Arad Territorial Administrative Unit in 2001 (HCLM 123/2001; Law 61/1993; Law 366/2001; Law 416/2001).

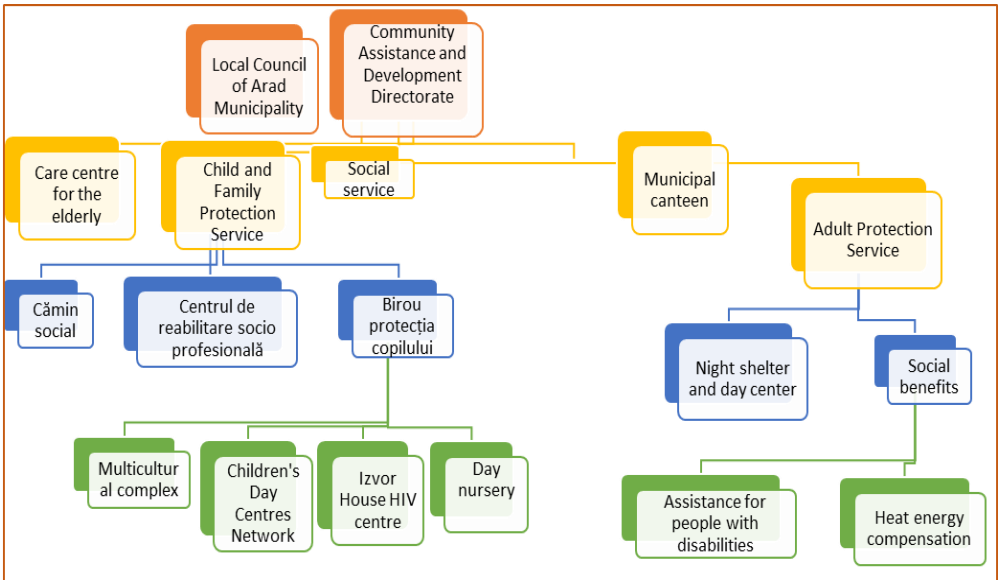


Source: Decision of the Local Council of the Municipality of Arad no.123/2001

Figure 1. Structure of existing social services at the level of the Arad Territorial Administrative Unit – 2001

The recalibration of the welfare system focuses on the national, county and local level. With a process of decentralization of social services to local governments, they are struggling to meet their need for social services. Pre-accession funding, public-public and public-private partnerships, however, bring a new breath to the social assistance system, at least at the level of municipalities/cities, so the start of the 2006-2013 strategic planning period bodes well. As can be seen in Figure 2, in 2006, the public social assistance service in Arad municipality provided a wide range of social services for various categories of beneficiaries. Compared to the existing services at the time of establishment, we now find child protection services organized at the level of a specialized department for child and family protection, which coordinates several departments for this category of beneficiaries. Primary social day services for children are now identified, which include a network of centers in the main districts of the municipality, as well as a multicultural social complex with the functionality of a day center for Roma children. Also, during this period, the Care Home for the Elderly is taken over by the public service, day services for the protection of the elderly are developed and the Service for the Disabled with two compartments providing community health care and home care. The night shelter that used to house homeless people develops its service, offering not only accommodation but also day services aimed at their socio-professional integration. The social benefits service is extended with two more departments dealing with assistance to disabled people and one for the compensation of thermal energy, a social protection measure granted to low-income people/families (HCLM 358/2006; HCLM 351/2010; HCLM 409/2004; Law 17/2000).

Comparing the initial social services with those existing in 2010, we can see that they have developed both in the category of community/private social services and in that of specialized services. We can also observe that the number of social benefits has changed, in the sense of expanding the range of benefits both in the area of people with disabilities and in the area of disadvantaged people or people at social risk.



Source: Decision of the Local Council of the Municipality of Arad no. 351/2010

Figure 2. Structure of existing social services at the level of Arad Territorial Administrative Unit – 2010

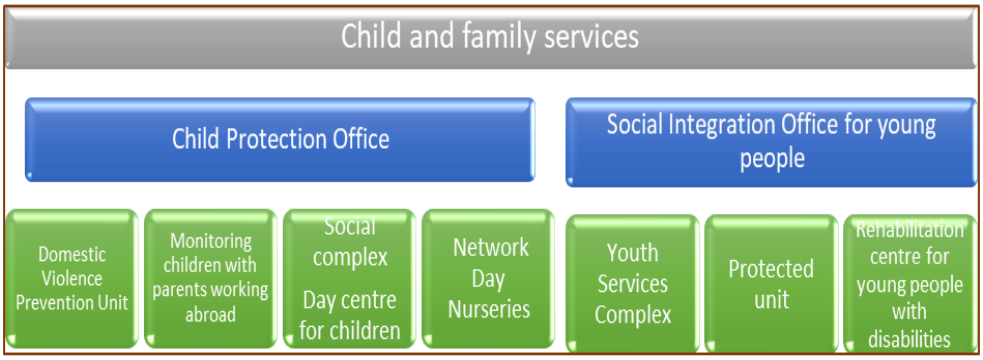
The categories of beneficiaries to which the public social assistance service refers to during this period are: children and families in difficulty, children at risk of family/school abandonment, young people from the social protection system, people/families at social risk or in extreme poverty, people with disabilities, homeless people and elderly people. Therefore, this period highlights the rehabilitation of some components of the social assistance system and we refer to the social benefit system, assistance to people with disabilities and community social services for disadvantaged children and families (HCLM 17/2012; Lazăr, F., Roșu, L., Cristea D. and Iovu M.B., 2020).

Analyzing the next period up to 2019, we note the emergence of new regulations on quality assurance in the field of social services, which aim to develop a unitary system capable of providing quality services reported to minimum quality standards. We observe the application of these regulations at the level of the public social assistance service in Arad municipality by obtaining in 2013 the permanent accreditation as a provider of social services

as well as the licensing of all social services for which this certification was required (Law 197/2012).

Regarding the categories of vulnerable people that stand out in this period, in Arad municipality we can distinguish three major categories of vulnerability: disability (5,577), belonging to the Roma ethnic group (2,528) and poverty (2,442). They are doubled by categories with a slightly lower incidence: young people and children in difficulty (285), families of children and young people in difficulty (255), people who cannot manage their lives alone (136), homelessness (80). However, it should be noted that due to socio-economic changes in the municipality, new categories of beneficiaries appear towards the middle of the reference period, namely victims of domestic violence and children whose parents have gone abroad to work (HCJ 309/2013; HCLM 306/2019).

During this period, we notice a coherent organization of social services and a promotion of these services in the community, which leads to accessibility. Social services are divided into categories of beneficiaries, so that at this moment we have social services for children and families, social services for adults, and common services, as shown in figures 3, 4, and 5 (HCLM 82/2014).



Source: Decision of the Local Council of the Municipality of Arad no. 82/2014

Figure 3. Child and family protection services

Looking back at the period 2013–2019, it can be seen that the services for children and families offered by the public social assistance service in

Arad are mainly aimed at identifying, monitoring, and preventing situations of hardship, preventing family and school dropouts, and respecting children's rights by providing assistance and support to families with children who, due to poverty, alcohol consumption, or deviant behavior, do not respect children's rights and do not fulfill their parental obligations. Thus, the Child and Family Protection Service coordinates the work of the Department for preventing and combating domestic violence, the Youth Social Integration Office, the Child Protection Office, and the Department for monitoring children with parents working abroad.

We note that at the beginning of 2019, the Department for the Prevention and Combating of Domestic Violence was established following the provisions of the updated Annex II of H.G. 797/2017, which refer to the obligations of local public authorities in preventing and combating domestic violence. Through this department, measures are taken at the level of Arad municipality in order to prevent, combat, and minimize the consequences of domestic violence, child abuse, and neglect, as well as human trafficking, aiming to reduce these phenomena and improve the living conditions of children and families. The services offered include social, psychological, and legal counseling; support for victims of domestic violence and family members to overcome trauma and mediate conflict; and counseling for children and families in crisis situations (family violence, neglect, various forms of abuse, and human trafficking). Within this department, there is also a mobile team that ensures emergency intervention through active inter-institutional collaboration with public or private law bodies (General Directorate of Social Assistance and Child Protection Arad, Municipal Police, Local Police, Border Police, NGOs, interested individuals or legal entities) (HCLM 25/2019; H.G. 691/2015; Law 272/2004).

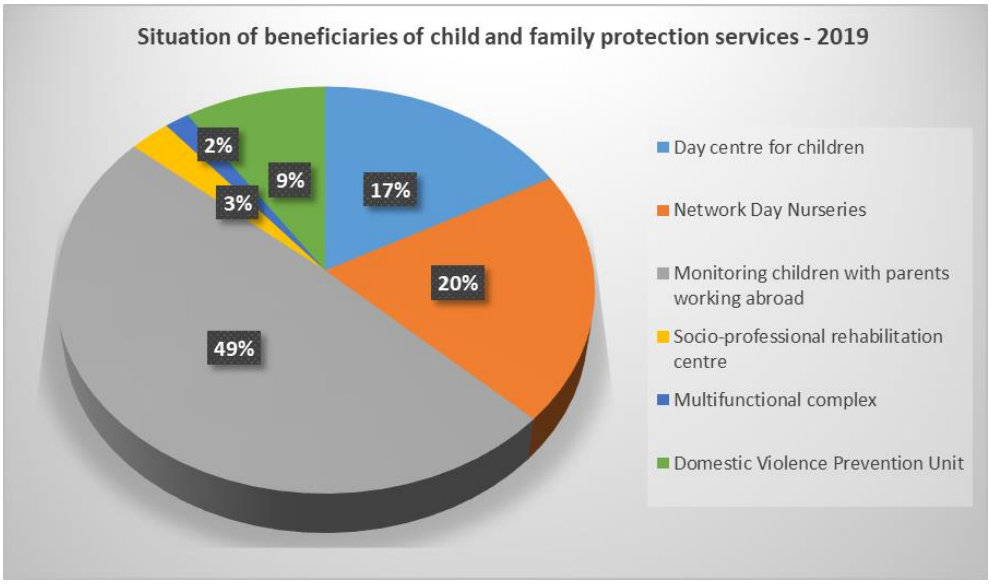
Analyzing the structure of the Social Integration Office for Children and Young People, we observe that it coordinates and methodologically guides the work of the Socio-professional Rehabilitation Center, the Protected Activities Department for Young People with Disabilities, and the Multipurpose Social Center. We can note that the Socio-vocational Rehabilitation Center and the Protected Activities Compartment for Young

People with Disabilities are two units that were established in 2013 as a result of the implementation of a project funded by the Human Resources Development Operational Program. The two units implement a socio-professional program aimed at young people with disabilities and their social and professional integration. While the first one deals with the development of personal and interpersonal skills such as communication, interpersonal, emotional intelligence, increasing self-esteem and self-awareness, behavior management and stress reduction, and cognitive abilities by stimulating attention, imagination, and thinking, the second one aims at increasing the level of self-sustainability and social integration, offering a job to people with disabilities in the sheltered unit and accompanying them to cope with the activities carried out. Also, as a result of the implementation of a project, this time financed by the World Bank, the Multipurpose Social Center for young people from institutions was inaugurated in 2014. The services offered in this center are both accommodation and counseling services, as well as support in professional orientation and employment (HCLM 17/2012; HCLM 67/2012).

Another component of child and family protection is the Child Protection Office, which coordinates three important segments of the range of services, namely the identification and monitoring of children in difficulty, the prevention of dropping out of school, as well as other activities aimed at respecting children's rights, the activity of the network of daycare centers, and the Intercultural Social Complex, which provides day services for Roma children. The Intercultural Social Complex is a day center located in an area with a large Roma community and aims to keep children in school in order to complete and finalize their compulsory education, and the counseling activity aims to prevent the separation of the child from his or her parents (HCLM 17/2012; Order 27/2019).

Because both the legislation that emerged with the problems that arose among children with parents working abroad and the complaints registered regarding this group of beneficiaries required the establishment, in 2019, of the Department for Monitoring and Promotion of the Rights of Children with Parents Working Abroad with the aim of identifying and

monitoring children with parents working abroad and those at risk because of this, as well as establishing the necessary measures to support the family if necessary, It is worth mentioning that, in addition to the social services provided by the Child and Family Protection Department, other measures or activities requested by other institutions are also carried out. Thus, we identify activities that consist of carrying out social surveys for children classified as disabled, obtaining scholarships (social and medical), and providing school guidance at the request of the General Directorate of Social Assistance and Child Protection Arad or the County Agency for Social Payments and Inspection (Law 156/2000; Order 219/2006; HCLM 251/2017).



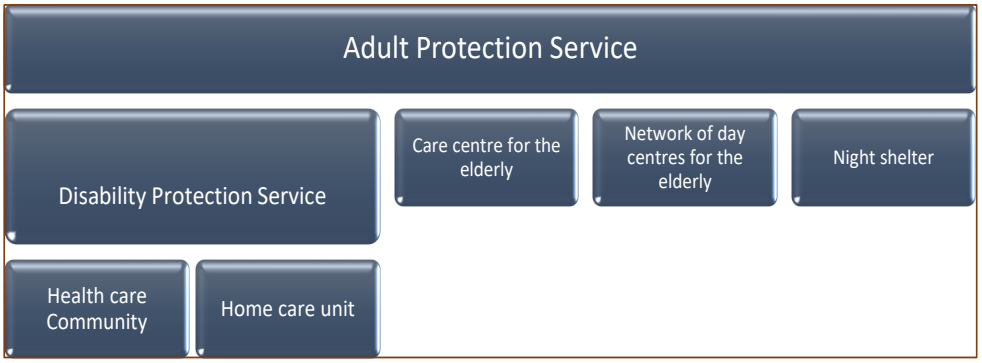
Source: DAS Activity Report 2019

Figure 4. Situation of beneficiaries of child and family protection services 2019

As we can see, the most beneficiaries are registered by the department for monitoring children with parents working abroad, which has processed 346 cases during 2019. The nurseries and the daycare center managed 148 and 126 beneficiaries, respectively, and the domestic violence prevention department intervened for 69 beneficiaries. The socio-professional rehabilitation center and the multifunctional complex for young people from the care system registered 20 and 12 beneficiaries, respectively.

From these data, we can see that the share of beneficiaries in this segment is occupied by children with parents working abroad, and the trend noted in the first half of 2020 is an increase in the number of beneficiaries identified. In this regard, it is considered that there is a need for the development of services for this type of beneficiary, an analysis of the effects that separation from parent(s) has on the child, and the identification of solutions to mitigate them (Activity Report of the Social Assistance Department, Arad 2019).

We turn our attention to social services for adults where we note the existence of a service for the protection of the disabled person with two components that relate to community health care and home care, a center for the care of the elderly, a network of seven-day centers for the elderly and a night shelter for the homeless (HCLM 82/2014).



Source: Decision of the Local Council of the Municipality of Arad no. 82/2014

Figure 5. Services for the protection of adults

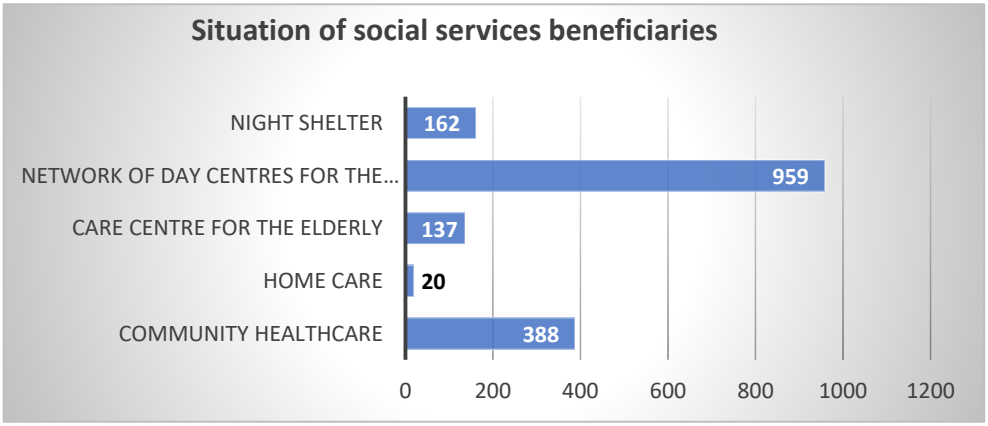
The Disability Protection Service is a service for dependent or semi-dependent people who are unable to care for themselves, with priority given to people at social risk without carers. The work of this service is carried out on two levels: one aimed at community care and one aimed at home care. Through community health care, health monitoring is carried out for the population in disadvantaged areas. Here, the steps taken range from accompanying the beneficiaries to issue identity documents to registering with the doctor and accessing medical services. In most cases, the work of the specialists is on the ground to identify and report the social cases

detected to the social services of the local authority. Through the home care service, we strive to prevent the institutionalization of elderly people, improve their quality of life, and maintain their functional autonomy in their own homes by providing support and assistance to elderly people isolated at home and preventing their social marginalization. We note that the group of beneficiaries of these services is made up of people with disabilities, dependent or semi-dependent elderly people without caregivers, people with medical and social needs, people over 65 years old, and families from disadvantaged areas (HCLM 251/2017; Law 292/2011; Order 29/2019).

As for the Arad Care Centre for the Elderly, it has a special history, with its functionality dating back to 1957 under various names and subordinations, namely Hospital Home for Chronic Non-recoverable Diseases, Hospital Home for Chronic Diseases, and Care and Assistance Centre Arad, until 2003 when it was subordinated to the National Authority for Persons with Disabilities. Since 2004, it has been reorganized as a care center for the elderly and taken over by the Arad public assistance service, under which it now operates. This center provides residential care services for elderly people who are partially or totally dependent and who are unable to carry out their daily activities on their own. The beneficiaries are elderly people (who have reached the retirement age established by law), living in Arad municipality, and who are in one of the following situations: they have no family or are not dependent on a person; they have no home and are unable to provide for their own living conditions based on their own resources; they have no income of their own or their income is not sufficient to provide the necessary care; they cannot manage on their own or require specialized care; they are unable to provide for their socio-medical needs due to physical or mental illness. The services they receive are based on basic and supportive care, medical care, and legal, social, and psychological counseling. It is worth mentioning that institutionalization in the center can be carried out only with the consent of the elderly person or, if the medical situation does not allow it, with the consent of the first-degree relatives or, in their absence, by decision of the public social assistance service of the local public administration authority where the elderly person has his or her domicile or residence (HCLM 409/2004; HCLM 251/2017; Law 17/2000).

Among the social services for adults, we find the day centers for elderly people in seven neighborhoods of Arad with the aim of supporting elderly people in difficulty and lacking social support and preventing their institutionalization and social marginalization. The services of the day centers provide beneficiaries with access to social, psychological and legal counseling programs, support in re-establishing or maintaining links with family members, medical assistance, food, social support in case of illness (HCLM 251/2017; HCLM 306/2019).

Among the first services offered by the public social assistance service in Arad municipality is the social service offered by the night shelter, which was established in 2000 and provides accommodation, social assistance, primary health care, and material support consisting mainly of food and clothing to elderly people, temporarily or permanently deprived of the possibility of securing a home. The beneficiaries of this center are usually people who are legally residents of Arad, but there are also beneficiaries who live in different parts of the country and who use the services of the night shelter, especially during the winter months. We note from the dynamics of beneficiaries that in the summer months the average daily number of beneficiaries is between 30 and 40 people, while during the cold season the capacity of the night shelter is exceeded annually, with the daily number of beneficiaries housed in the cold periods often exceeding 70 people (Law 17/2000; Order 29/2019; HCLM 376/2000).

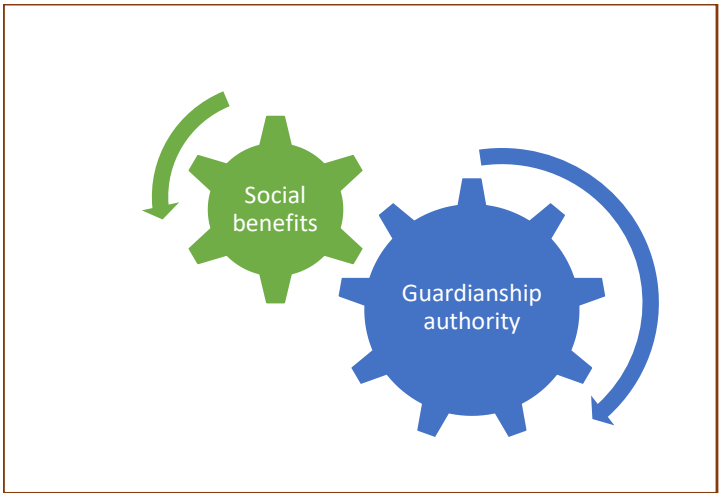


Source: DAS Arad Activity Report 2019

Figure 6. Situation of social services beneficiaries

It can be seen that the highest number of beneficiaries is the network of day centers representing 57% of the total number of beneficiaries, followed by community health care which accounts for 23% of the total number of beneficiaries of social services for adults. A percentage of 10% is represented by the number of homeless beneficiaries, 8% elderly people in residential centers and 2% are beneficiaries of home services (Activity Report of the Social Assistance Department Arad 2019).

It is also necessary to address the services of the Guardianship Authority and Social Benefits that carry out essential activities in terms of social benefits and some issues related to the legality of some actions concerning families with dependent children, elderly people who want to conclude maintenance contracts, or who, due to their physical condition, need a representative or administrator (HCLM 251/2017).

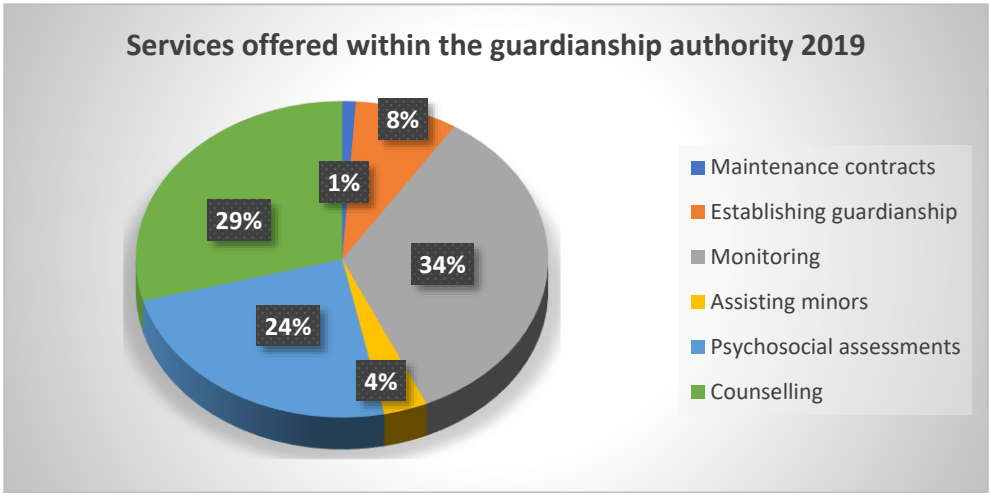


Source: Decision of the Local Council of the Municipality of Arad no. 82/2014

Figure 7. Shared social services

Among the objectives of the guardianship authority service are respect for the rights of the child, the rights and dignity of the elderly and disabled. The service's activities include assisting the elderly in establishing maintenance contracts, drawing up documentation for the establishment of curatorship for the elderly or the sick, and monitoring maintenance contracts. In the field of child protection, we distinguish activities to assist minors in

accepting inheritances. At the request of the courts, it carries out psychosocial assessments in divorce proceedings and provides legal, social, and psychological counseling to children and parents (Order 1733/2015; Law 272/2004; Law 448/2006).



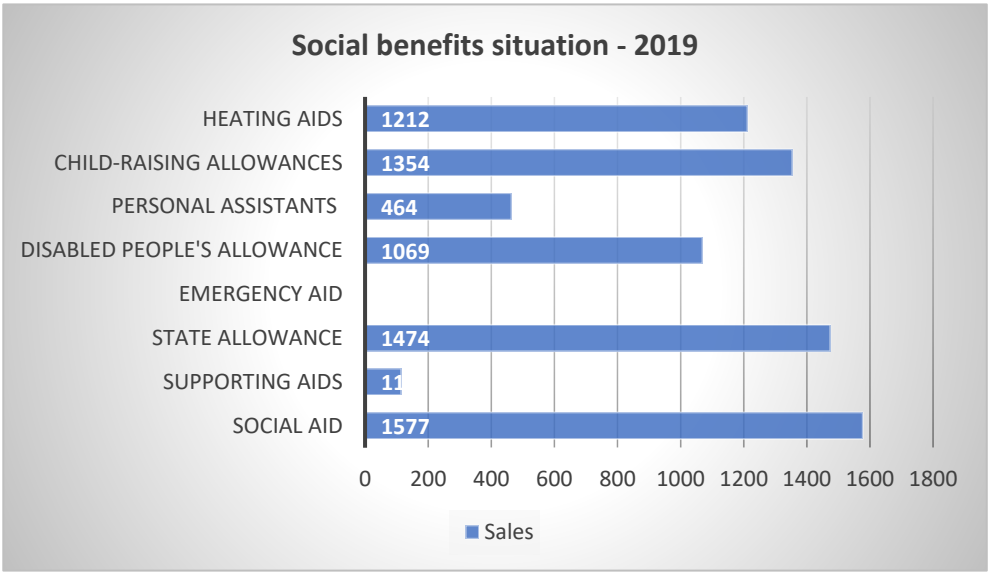
Source: DAS Arad Activity Report 2019

Figure 8. Services offered within the guardianship authority 2019

As can be seen, a large part of the service's work is taken up with case monitoring, whether it is post-divorce monitoring, guardianship monitoring, or maintenance contract monitoring, which represents 680 cases. Counseling of children and parents who are in the process of divorce or are divorced totals 582 cases in 2019, and psychosocial assessments requested by the courts account for 478 cases. With regard to the establishment of curatorship, 161 cases were processed, and 21 elderly persons were assisted in concluding maintenance contracts. Regarding the representation of children in the exercise of the right to administer property, 68 minors were assisted (Activity Report of the Social Assistance Department, Arad 2019).

A complex task is carried out by the Social Benefits Service, which deals with the local implementation of national social benefits legislation. The work of the service has been notable since 1995, when it was among the first social services established under the Territorial Administrative Unit, and it became part of the public social assistance service in 2001. Among the

benefits granted by the Social Benefits Service are: social assistance, family support allowance, state allowance for children, emergency aid for persons at social risk, granting of the allowance for an attendant or hiring of a personal assistant for the severely disabled person with a personal assistant, taking over files for the monthly child-raising allowance, and granting of aid for home heating (HCLM 159/2003; HCLM 187/2012; Law 416/2001).



Source: DAS Arad Activity Report 2019

Figure 9. Social benefits situation 2019

We can see that the share of social benefits is occupied by social aid, which registered at the end of 2019 a number of 1577 beneficiaries, followed by the state allowance with 1474 beneficiaries, child-raising allowances with 1354 beneficiaries, heating allowances with 1212 beneficiaries, and allowances for severely disabled people with an accompanying person, which were in the number of 1069. Not to be neglected is the number of personal assistants (464), who are employees of the public social assistance service with a special status (Activity Report of the Social Assistance Department Arad 2019).

The identification of social needs is a complex activity that requires complex action to continuously evaluate and monitor the effectiveness of the

measures addressed. The pressure that is sometimes put on the social assistance system is underestimated, and we have a very topical example generated by the health crisis in the context of the spread of the SARS-COV2 virus when new vulnerable groups emerged, the need for services to respond to them, the training of staff and specialists to meet the requirements, but also the institutional capacity to adapt to the situation. Thus, I believe that in order to be able to face social and economic challenges, people need sustainable social protection systems. Social welfare services are the basis for the sustainability of economic and social development because when people are empowered, they become active in the labor market and are able to contribute to the development of their own conditions and those of the communities they belong to (Zamfir, E., Voicu M and Stănescu, S.M., 2020).

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"It's all about being a part of something in the community, socializing with people who share interests and coming together to help improve the world we live in."
Zachary Israel Braff

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