Adapting services

for persons with disabilities

to new users

Executive Summary of Findings & Partnership Recommendations

Lifelong Learning Programme

This project has been funded with support from the Lifelong Learning Programme.

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1 PROJECT PARTNERS AND CONTRIBUTORS ..... P. 4

2 PROJECT PURPOSE ..... P. 5

3 PROJECT OBJECTIVES ..... P. 5

4 PROJECT ACTIVITIES ..... P. 5

5 DEFINITIONS ..... P. 6

6 PROJECT FINDINGS ..... P. 6

6.1 ▶ Analyse and better understand the causes of the diversifying of users of service providers traditionally supporting and caring for persons with intellectual disabilities, in relation with the economic, social and policy contexts. .....P. 6

6.2 ▶ Identify and better understand the challenges met by service providers, in particular in terms of staff skills and training. .....P. 7

6.3 ▶ Take stock of strategies implemented by funding authorities to respond to the diversifying of users. .....P. 9

6.4 ▶ Compare and assess practices in order to identify good practice, in particular concerning staff skills and training - Take stock of strategies implemented by service providers to respond to the diversifying of users. .....P. 10

7 PROJECT RECOMMENDATIONS ..... P. 13

8 CONTACTS ..... P. 17

1 PROJECT PARTNERS AND CONTRIBUTORS

Seven organisations from seven different countries belong to the partnership:

- Jugend am Werk, **Austria**;
- EASPD, **Belgium**;
- Unapei, **France** (coordinator);
- Hand in Hand Foundation, **Hungary**;
- PSOUU Jarosław, **Poland**;
- CECD Mira Sintra, **Portugal**;
- Learning Disability Wales, **UK**.

In addition, the following organisations have also contributed to the work of the partnership at one stage or the other:

- **Austria**: Verein zur Schaffung alternativer Beschäftigungsmöglichkeiten für psychisch Kranke, Wiener Sozialdienste Förderung und Begleitung GmbH, and LOK – Leben ohne Krankenhaus;
- **Belgium**: ASBL Le Huitième jour, and vzw den achtkanter;
- **France**: Adapei 28, Adapei 77, Adapei 79, AJH, and Papillons Blancs de Lille;
- **Portugal**: Centro de Educação Especial Rainha Dona Leonor – CEERDL, and FENACERCI;
- **The Netherlands**: Stichting IZAH;
- **Wales, UK**: Cartrefi Cymru and Elite Supported Employment.

While some partners and contributors are umbrella organisations for their sector at regional or national level, others are individual service providers whose response is based primarily on the situation in their services. The results of the partnership should therefore be considered as the views of the organisations involved, rather than fully representative of the situation and thinking in the participating countries.

2 PROJECT PURPOSE

The purpose of this partnership project was to ensure that the skills of staff of service providers for persons with an intellectual disability match the developments in the sector. The ultimate aim of the project was to provide quality and innovative support for all users of the partner's services, meeting their needs. Our main focus was services provided for persons with an intellectual disability in the fields of education, vocational training, work and employment, and independent living.

3 PROJECT OBJECTIVES

The concrete objectives for the project were to:

- analyse and better understand the causes of the diversifying of users of service providers traditionally supporting and caring for persons with intellectual disabilities, in relation with the economic, social and policy contexts;
- identify and better understand the challenges met by service providers, in particular in terms of staff skills and training;
- take stock of strategies implemented by service providers and/or their funding authorities to respond to the diversifying of users;
- compare and assess practices in order to identify good practices, in particular concerning staff skills and training;
- compare and contrast the findings to formulate recommendations for service providers, vocational education and training (VET) providers, policy makers, and funding authorities.

4 PROJECT ACTIVITIES

We worked to fulfil the objectives for the project by undertaking a range of activities. The most significant of these were:

- peer learning between service providers concerning the causes of diversification of users, the specific needs of new users, the challenges faced by service providers and the range of possible strategies adopted to respond to the diversifying of users;
- exchange of best practices across Europe's main regions;
- sharing of expertise between local, regional, national and European levels;
- field visits and case studies;
- involvement of grassroots professionals;
- involvement of users in local activities.

And most importantly:

- **the elaboration of common recommendations arising from the activities undertaken and the project findings.**

5 DEFINITIONS

Partners referred to the definitions below throughout the project.

'Current users' are persons with an intellectual disability (= learning disability, including persons with multiple disabilities).

'New users' are:

- persons with a mental disability (= mental health problems, mental illness);
- persons with a dual diagnosis (= persons with an intellectual disability and a mental disability);
- persons in a situation of social exclusion (= persons who do not fall neatly into a diagnosis of intellectual disability, or mental disability, or dual diagnosis, but who are vulnerable, distant from the labour market, and who need to be supported by services in order to be socially included).

6 PROJECT FINDINGS

We report our project findings under the relevant concrete objective identified for the project:

6.1 ▸ Analyse and better understand the causes of the diversifying of users of service providers traditionally supporting and caring for persons with intellectual disabilities, in relation with the economic, social and policy contexts.

To fulfil this objective we conducted a survey amongst project partners, to gain both an understanding of the extent of the diversification of service users in each partner country, and of the profile of these new service users. Analysis of the data gathered from a questionnaire completed by project partners resulted in the findings below. We have grouped into findings about the extent of diversification of adapted services and the causes of diversification.

EXTENT OF DIVERSIFICATION

In all countries, service providers for persons with an intellectual disability are also supporting persons with **dual diagnosis**. However, in some countries they support all individuals with dual diagnosis, and in others only individuals whose intellectual disability is the most prominent aspect of their life.

In all countries, except Portugal, service providers for persons with an intellectual disability also support persons with a **mental disability** only. However, the extent of this diversification varies from country to country, and even from service provider to service provider.

In all countries, except Poland, service providers for persons with an intellectual disability also support people in a situation of **social exclusion**.

In all countries, some service users combine a mental disability, an intellectual disability, and social exclusion, leading to challenging situations.

In some countries (France, Austria, Portugal), new users are actually not new, especially when it comes to persons with dual diagnosis. However the acknowledgement of this diversification is quite new. This probably reflects improved identification and knowledge of these users' needs, and improved diagnosis. Besides, there are more and more persons with dual diagnosis in the services.

In other countries the phenomenon is more recent.

> Based on these findings, in the course of the project we have tended to focus our analysis on the situation of persons with dual diagnosis, of persons with mental disability, and of persons combining a disability with a situation of social exclusion.

CAUSES OF DIVERSIFICATION

When looking at the causes of diversification, one is common to all countries: more persons with an intellectual disability are **also experiencing mental disability**. These mental disability problems are mainly mood disorders, anxiety and stress related disorders, personality disorders, schizophrenia, and dementia.

Other widely spread causes of diversification are the lack of diagnosis, better diagnosis, **a lack of/poor assessment** or a lack of care plan, the recognition of mental health problems as a disability, the absence or **lack of services** for persons with dual diagnosis, a shortage of services for persons with mental disabilities, ageing, and a change in families' level of care.

> While for some causes it seems possible to categorize countries according to their history or approach (e.g. closure of psychiatric institutions in some Western Europe countries), other causes can be found in countries with different histories or approaches (e.g. lack of diagnosis). This is consistent with the fact that the phenomenon is occurring in all countries.

6.2 ▸ Identify and better understand the challenges met by service providers, in particular in terms of staff skills and training.

To fulfil this objective we conducted a survey amongst project partners to identify and better understand the challenges met by service providers facing a diversification of users, in particular in terms of staff skills and training. Analysis of the data gathered from a questionnaire completed by project partners resulted in the findings below. We have grouped them into general findings and those that relate more specifically to staff and to service users.

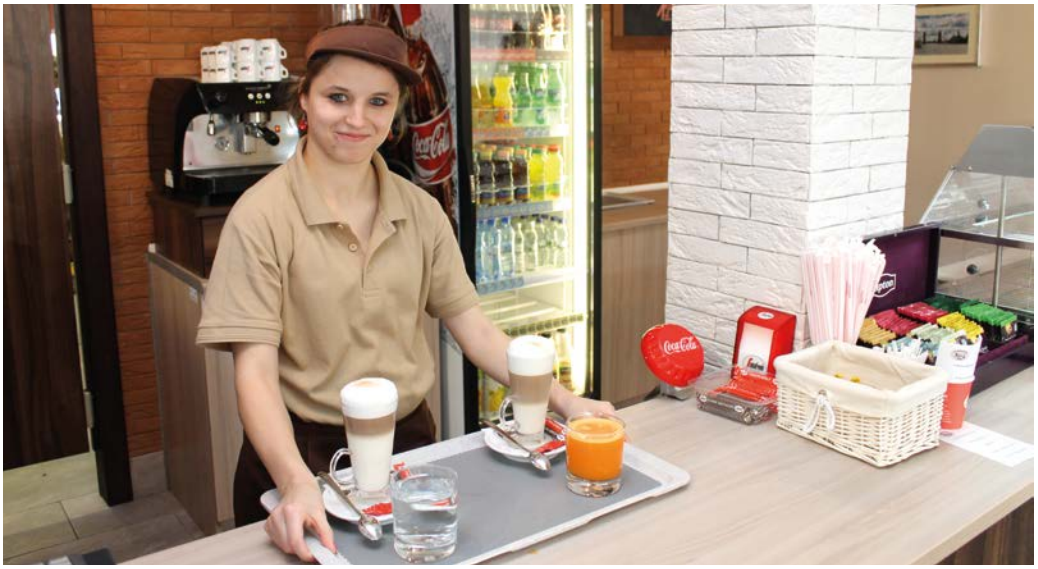
GENERAL FINDINGS

Facilities and funding. Organisations from all countries reported that there are mixed facilities that are tailored to the specific needs of new users, but only organisations from Austria, France and Hungary stated that specialized facilities also exist for new users. The most common funding source, either in mixed or in specialized facilities, is public funding. In some countries, some funding also originates from private foundations.

Individualised support. This is a key factor in ensuring a successful adapted service, where users are satisfied. Individualised support was identified as the most common way to support new users who have difficulties in expressing themselves. A Welsh partner referred to link workers, i.e. a person who works with the service user to really get to know him/her well, and supports the service user to create his/her person-centred plan and during care reviews. Many services in other countries also have such link workers.

Access to adapted services. There is a great variation across partner countries in how readily service users can access services of this type. For example services can be accessed immediately in the Netherlands, but in Hungary there can be a wait of up to a maximum of 6 months. In France it can sometime take years.

Composition of multidisciplinary team and staff training on how to support new users. Organisations from Austria, France, Hungary, Poland, Portugal and Wales believe that a multidisciplinary team is very important. Only organisations from Austria and Wales reported that there are appropriately trained staff for working with new users. All other partner organisations claimed that the quantity of trained staff is insufficient.



Space and equipement. Half of partner organisations believed that the allocation of space and equipment is appropriate.

Service methodology. The majority of organisations did not identify a specific methodology that they used with new users. The exception was the Netherlands, where the respondent identified the SIVUS[1] method. Flexible support structures that cover the needs of new users can be found in all organisations. Nevertheless sometimes there can be a gap between official practices and actual implementation.

> Other challenges included the reduction in public funding due to the financial crisis, the need for improved staff training, improved diagnosis and working more effectively in collaboration with healthcare service providers.

STAFF FINDINGS

> **Education and training.** Only partner organisations from Austria and Hungary reported that the issue of new users is addressed fully in education and training in the social care sector. In France, Poland, and Portugal, the topic is partially covered.

Expert staff. The data suggested that there are few specialised medical staff (including psychiatrists) and psychologists in services. In some countries there is a need for more pedagogical staff.

> **Mandatory qualifications and training.** In none of the partner countries are there mandatory qualifications for staff members working with new users. However many organisations require their staff to have special qualifications to work with new users, as for instance reported by the Austrian partner. Partners in Austria, France and Wales state that relevant staff members are provided with training programmes to better support new users.

Critical situations. Critical situations are handled in different ways. Nearly all organisations reported that teams contact external experts. Another tool is detailed guidelines for staff. Prevention is also key. Teams are supported through specialist supervision in Austria, France and Belgium.

Co-operation and networking. On co-operation and networking, nearly all partners reported on existing exchanges with other service providers and experts. However it was believed that the sharing of information and close cooperation with experts needs to improve as only half of the organisations reported that good quality, close cooperation was present.

> Challenges concerning staff members include the need for specific training and the improvement of networking structures.

1. The Sivus Method is a Swedish concept named 'Social Individ Via Utveckling Samwerkan'. It includes individual training in group situations at the actual workplace, is tailored to the needs of the service user and is based on a one-on-one approach.

SERVICE USER FINDINGS

Admission to service criteria. The first point to note was about access to a service. In Belgium, Hungary, the Netherlands and Poland the admission criteria for new users are the same as for other users. In Austria there is a criteria that admission does not raise the risk of harm to existing users. In France, Portugal and Wales, service providers look at whether the admission of the new user might jeopardise or not the quality of support for the other users.

Person centred approach. The results of the survey highlighted the importance of adopting a person centred approach in providing direct support to new users. The design of service feedback routes also reflected this commitment: users are able to express their needs and wishes in nearly all organisations through one-on-one interviews as well as surveys. In some cases these options were supplemented by the identification of user representatives or the creation of self-advocacy groups in service settings.

Participation of third parties. In Austria, France, the Netherlands, Poland, Portugal and Wales the involvement of families and external supporters only takes place if it is necessary and/or the user requests it.

> Other challenges concerning service users include securing better funding so that the quantity and quality of service can be improved, implementing new, innovative services, and the full inclusion of users.

6.3 ▸ Take stock of strategies implemented by funding authorities to respond to the diversifying of users.

We found that the approach adopted by funding authorities towards adaption of services to new users varies significantly across the partner countries.

In **France**, government policy actions have explicitly encouraged social care support for new users. In the years since 2005, service providers have been encouraged to develop a pattern of 'mixed' and 'specialist' services though very little extra funding was provided. Main growth has been in the field of 'mixed' services, which whilst initially only catering for people with an intellectual disability and some people with a dual diagnosis, now also support individuals with a mental disability and more people with a dual diagnosis. Support for this adaptation, whether in the field of funding, training or in developing collaboration with health services, is only at the embryonic stage. 'Specialist' services are dedicated solely to people with mental disability, but there are very few of them. No services dedicated to the support solely of people with a dual diagnosis have developed.

In **Portugal** there has been a major, but more organic trend to diversification. There is a greater tendency for mental health services to be provided in the community and accordingly less reliance being placed on institutional hospitals. Debate about meeting the needs of people with a dual diagnosis has been encouraged. However the trend to adapting services to new users has not been accompanied by any new assistance on funding or training.

In **Poland** a trend to adapt services has been encouraged by a high profile policy initiative to change attitudes to people with mental disability and to greatly improve services. Diversification is still at an early stage. Where funding to adapt services has been required it has usually been secured by NGOs through independent sources.

The picture in the countries where the other project partners are based is that there has been no explicit statement by the respective governments and funding authorities that services should adapt to assist new users. Some factors have combined however, to see some evidence of services being adapted.

In **Austria and Hungary**, governments have continued to maintain the separation of health and social care. In Austria service providers that specialized in supporting

people with mental disability problems do not accept people with dual diagnosis or people with intellectual disability as service users. Service providers for persons with intellectual disability try not to accept persons with mental disability problems but do accept persons with dual diagnosis.

In **Belgium** there have been steps to identify the needs of some new users and encourage services to work more seamlessly to support them. This has extended beyond policy statements aimed at people with a dual diagnosis, to creating a multi-agency model of care, joint planning by health and social care agencies and the delivery of targeted services by dedicated staff teams.

In **Wales**, whilst the need to adapt services to support people with a dual diagnosis has been acknowledged at a policy level, more practical progress has been made in providing better support and access to services for people on the autistic spectrum. Some diversification has also occurred as an unintended consequence of government policy to create a market where there are a range of potential service providers who can be commissioned to provide services. This has encouraged some providers to work with new users. To some extent the adaptation of services has been hampered by health and social care needs being funded by different agencies, even though the role of care manager, which is an established part of Welsh government policy, may make the co-operation smoother than in other countries.

More should be done. For countries represented in this project, some encouragement to diversification has therefore been identified in policies, but funding has been inadequate. In most countries, other types of proper support and assistance have also been inadequate.

6.4 ▸ Compare and assess practices in order to identify good practice, in particular concerning staff skills and training - Take stock of strategies implemented by service providers to respond to the diversifying of users.

To fulfil these objectives we asked all partners to identify good practice in their region or country and to report on each example using two templates prepared and agreed by the partnership. Based on the results of the survey on challenges, partners were requested to pay special attention to eight fields. Using the best practices as a starting point, partners further elaborated on the results to identify good strategies to overcome the challenge of adapting services to new users. Analysis of the data gathered from this process resulted in the following findings.

Multidisciplinary teams. All partners identified examples of best practice and believe that multidisciplinary teams are an important element in any strategy. Interaction and co-operation are key to achieve high levels of efficiency and efficacy. The existence of a multidisciplinary team facilitates the exchange of knowledge between social care, paramedical and health care staff.

The teams should include experts with specific know how and skills in the field of mental disability and in the field of intellectual disability. This expertise could be contained within the team or drawn on from the wider community.

There should be close collaboration between different stakeholders in order to provide the most adaptable solution to each person needing support. This is the role, in some countries, of the coordinator or case manager.

Partnerships. Partners placed emphasis on the importance of creating active and meaningful partnerships to ensure success in adapting a service.

A key relationship to nurture is with representatives of the health sector and particularly mental disability experts and providers. Networking and co-operation with experts and the health sector was identified as an important factor in the majority of selected best practices, which secures added value for all stakeholders. Particularly in cases where an individual has a dual diagnosis, co-operation enables the delivery of better services with significant improvements to the user's quality of life. Indeed such partnerships improve awareness of dual diagnosis, referral,

access to psychiatric care, continuity of support, diagnosis and needs assessment. They also enable sharing of methods and expertise, and exchanges of knowledge and best practices. In its most developed form, partnership with the health sector can even offer an integrated model of care (integrating social and health care).

It is also important to develop a close partnership with other stakeholders in the social sector, public authorities, families and the local community.

Training of staff. Training of staff members who are working in a newly adapted service was recognised as necessary so that they are ready to respond effectively to the differing needs of new users of a service. Training of the multidisciplinary team is critical both at the initial training stage and as a regular activity. Training courses might include understanding psychiatric illness or dual diagnosis, managing heavy behavioural disorders, or helping the service user to become more independent. Courses are recognised as more efficient if they make the link between up to date theoretical research and the concrete experience of front line staff. On the job training can also contribute to a better understanding of the user's needs and enable a better design of solutions. Training might also be conducted through immersion placements, supervision and analysis of practices, and exchanges within the multidisciplinary team and with partners in the health sector. It is important to thoroughly assess training needs, and to evaluate training activities.

Person centred approach. Several examples of best practice identified the use of a person centred approach. Services at the cutting-edge that wished to adapt to new users put a Person Centred Planning Model[2] at the centre of their work.

Generally speaking, service providers have adopted a person-centred approach, based on **appropriate diagnosis and holistic assessment**. Including in services that are adapting to new users with a dual diagnosis, a correct diagnosis and use of an appropriate assessment tool[3] by a multidisciplinary team greatly assists in improving the

users' quality of life. An holistic assessment should taking into account the valuable insights of all stakeholders; that is, the individual themselves, their family and close relatives, health and social care sector professionals. The assessment is subject to regular review and updating.

In a person-centred approach, support is swiftly adapted to the changing needs of the persons, on a day to day basis if needed, contributing to the prevention of a crisis situation. Prerequisites are a good knowledge of the person, and a constant sharing of information. It can be an enabling factor if people are supported in small scale settings. The result of this approach is a model of care closer to the individual, tailored to their needs and promoting their quality of life and rights of citizenship.

Innovative services. Some examples of best practice were identified as being innovative for new users by some organisations.

2. 'Person centered planning' is a process-oriented approach to empowering people with disability. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society. Person-centered planning involves the use of a 'toolbox' of methods and resources that enable people with disability to choose their own pathways to success. The planners simply help them to figure out where they want to go and how best to get there.

3. Hand in Hand Foundation's assessment method for the purpose of getting individuals into work was identified as a best practice. Called LANTEGI, it has been adapted to the needs of persons with mental disability. For more information, please see the Summary report on best practices (available on the project website).

The more flexible and responsive a service is, the more it will be able to adapt to new users. This flexibility could for instance be about the working hours of the service, or linking with another existing service to widen the options that may be available to the potential new service user.

Funding. For most of the best practice examples, the presence of stable public funding was critically important. In some cases, restrictions on funding prevented the service growing or expanding its role. Some services might disappear if the funding stops. Adaptation of a service will only succeed if close attention has been paid at the outset to how it will be funded.

Participation of service users. Service users' participation in the planning of the service is also key. Service providers put an emphasis on the direct involvement of users, using appropriate communication tools. Adapted services also benefit from the presence of user representatives who are supported in their role, and from participation of users in self-advocacy groups.

Inclusion of users. All the examples of best practice that were identified by the partners support an ambition that the users of their service should be fully included in society. Some of the services work specifically to achieve that goal. This model fosters social inclusion, values the persons, and gives outcomes such as an increased quality of life, a sense of purpose, self-confidence, a circle of support, and friends. It also provides an incentive to persons with dual diagnosis or mental disability for the establishment of a virtuous circle.

Several partners emphasized the importance of adapted services adopting a community based model to foster inclusion, access to services and partnerships. Achieving this feature is assisted by using existing facilities in the community like public services, companies, schools, public cultural locations like a theatre, religious bodies, and by forming collaborations with community organisations and stakeholders.

Transferability of best practices. Many practices are transferable, in particular where they relate to smaller scale issues. Other practices might be more difficult to transfer because of differences in national contexts.

7 PROJECT RECOMMENDATIONS

Our recommendations are addressed to policy makers and funding authorities, to disability service providers, to health care services and professionals, and to vocational education and training providers.

RECOMMENDATIONS TO POLICY MAKERS AND FUNDING AUTHORITIES

To respond to diversification, public authorities and funders should take several steps:

1 Acknowledge the existence of dual diagnosis, and finance and support research and development on new users.

2 Provide stable, adequate and flexible funding, covering all the needs of the user, and enabling service providers to, inter alia, maintain or improve the level of qualifications of their staff.

3 Encourage inter-agency collaboration and networking, including between the social care sector (including disability services) and the health sector so that both sectors work as partners in order to ensure a smooth and integrated support of individuals by both sectors, to develop more appropriate services, to secure improved staff training, and to achieve the overall aim of the full inclusion of service users in society.

This should for instance encompass the creation of resource centres to support persons with dual diagnosis, inter-agency and multidisciplinary coordination platforms, support to the use of telemedicine, promotion of the role of case managers, support to joint events, etc.

4 Ensure that appropriate training is provided, including through legislative frameworks and funding schemes facilitating ongoing vocational education and training.

5 Across each country, set standards for the qualification of staff, including to ensure that staff from the social care sector generally have the competencies to work with people with mental disability or dual diagnosis, and staff from the medical sector the competencies to treat people with intellectual disabilities and dual diagnosis:

- all staff members working in services for persons with disabilities should be required to have received accredited training and to have achieved defined qualifications. Staff members who are expected to work in adapted services should be required to have received training and qualifications ensuring that they have competencies to meet the needs of their new service users;
- the curriculum for social care (social workers, psychologists) and the one for the medical sector (doctors, nurses,…) should include learning outcomes related to intellectual disability for the medical curriculum, and related to mental health for the social care curriculum.

6 Provide an evidence-based assessment of what are the needs in terms of services for new users, and make sure that services have the means to contribute to this assessment process.

7 Promote evaluation of practices, benchmarking, and best practices.

8 Organise policy dialogue on these issues, as well as consultations of all relevant stakeholders.

9 Pay attention to securing earlier diagnosis and assessment of people with an intellectual disability who may be believed to have other, health-related conditions, and to enable them to receive lifelong check-ups as well as regular assessment reviews.

10 Create opportunities to assist the exchange of good practice, co-operation and networking at European level. Mobility of staff to be trained by experienced staff in dual diagnosis in other countries should be encouraged, as well as exchanges of expertise around assessment of dual diagnosis.

RECOMMENDATIONS TO DISABILITY SERVICE PROVIDERS

1 Service providers should draw up an action plan around dual diagnosis and mental disability, in order to ensure a multidimensional and comprehensive strategy. Holding regular meetings around the issue foster exchanges of expertise and help assess progress.

2 Adapted services should be built or developed with a commitment to individualised support of the service user at their core. A person-centred approach will facilitate the adaptation of services to new users and prevent crisis situations, by ensuring a good knowledge of the person and that everybody's needs are met in a timely manner with tailored solutions. Such an approach must be formalised at the organisation's level. Such an approach is facilitated by small units, a good staff ratio (in some cases: one to one support), and flexibility. Quality of life-related outcomes should be measured.

3 Adapted services should also be built or developed with a commitment to a holistic approach, which will facilitate the adaptation of services to new users and prevent crisis situations occurring. A holistic approach implies regular and adapted assessments, care management, a join up and close cooperation of services, well trained and supported multidisciplinary teams which can cater to mental health needs, close cooperation with key partners (incl. the health sector and families) and exchanges of expertise.

4 Adapted services should use person centred planning approaches to identify and meet the needs of their users. This includes using the right communication tools, including information and communication technologies, to ensure a proper dialogue with users with communication limitations.

5 Well trained and supported multidisciplinary teams mean that:

- adapted services should be based on a multidisciplinary team approach that secures input by all key professionals, including the implementation of a human resources policy to recruit expertise;
- staff in adapted services should be able to access advice and support from appropriate experts;
- staff in adapted services should receive regular support and supervision to help them respond effectively to the challenge of meeting the needs of new service users;
- staff of services for persons with disabilities should receive adequate training: their training needs should be thoroughly assessed and a staff training policy should be implemented based on the results of the assessment. Training activities and their impact should subsequently be evaluated. In adapted services, adequate training should include support to new users;
- managers should be trained on how to convey the organisation's approach to support to new users to front line staff, and on how to understand staff's difficulties and solve them;
- training should include teaching staff how to overcome communication limitations of persons with intellectual disabilities, to help reach a proper diagnosis of other conditions (in spite of communication limitations, analyse behaviours and understand their causes, recognise dual diagnosis signs,…).

6 Adapted services should ensure that there are mechanisms in place to ensure that service users have a voice that can comment on the quality of service they receive and contribute to the planning and running of the service.

7 Adapted services should ensure that there are mechanisms in place to secure feedback from the relatives and friends of service users, with the service user's agreement.

8 In order to foster coexistence, users should receive easy-to-understand information about their disability and other peoples' disability, and about difficulties it might entail.

9 Adapted services should pay attention to the environment (architecture, etc.). A quiet and stimulating environment is important for persons with dual diagnosis or mental disability.

10 Adapted services should be community-based and aim to be inclusive. Welcoming communities are needed. Some awareness raising efforts must be conducted to raise awareness amongst local communities on disability and accepting our differences.

RECOMMENDATIONS TO HEALTH CARE SERVICES AND PROFESSIONALS

Many of the recommendations to disability service providers likewise apply to health care services:

1 Health care services too should be built or developed with a commitment to individualised support of the service user at their core, with person-centred approach.

2 Health care services provision too should be built or developed with a commitment to a holistic approach.

3 Health care services too should use person centred planning approaches to identify and meet the needs of their users.

4 The same considerations about trained and supported multidisciplinary teams apply.

In addition:

5 Health care services and professionals should be aware of the existence of dual diagnosis and should cooperate with the social care sector as follows:

- link up with disability experts in disability to exchange views & experiences (events, platforms, …) and develop joint lobbying activities;
- work with disability service providers to ensure good knowledge of a person's medical condition and to provide appropriate and continuous support to the person, and avoid crisis situations;
- organise exchange of staff and training.

6 Health care services must assume that new users are having insufficient health care support[4] and develop action plans to meet their mental health needs.

7 Health care professionals should develop inter–relationships skills for working with persons with intellectual disabilities and persons with mental disability, in order to achieve greater efficiency on addressing new users individual needs.

4. See POMONA Project report - www.pomonaproject.org

RECOMMENDATIONS TO VOCATIONAL EDUCATION AND TRAINING PROVIDERS

1 A 'competence map' should be created to identify which competences staff needs to support new users in an effective way (skills, methodology etc.), both for social care and health sector staff.

2 Training providers should work with service providers to ensure training programmes adapt to the needs of staff supporting new users, both in initial training programmes and in continuing education, both for social care and health sectors staff.

3 Training courses should be built on both up to date research and front line staff experience.

4 Persons with disabilities should be involved in training, as well as professionals from both the social care and health sectors.

5 Where possible, training should be accredited.

6 When needed, training should be adapted based on the service providers' needs.

7 Training should be evaluated and updated in an ongoing way.

8 Immersion placements should be organised, in the social care sector for health professionals and in the health sector for social care professionals.

8 CONTACTS

FRANCE (COORDINATOR):
Union nationale des associations de parents, de personnes handicapées mentales et de leurs amis (Unapei)
Céline Simonin: **c.simonin@unapei.org**
www.unapei.org

AUSTRIA:
Jugend am Werk Begleitung von Menschen mit Behinderung GmbH
Ksenija Andelic: **ksenija.andelic@jaw.at**
www.jaw.at

BELGIUM:
European Association of Service Providers for Persons with Disabilities (EASPD)
Katrijn Dekoninck: **Katrijn.Dekoninck@easpd.eu**
www.easpd.eu

HUNGARY:
Hand in Hand Foundation – Kézenfogva Alapítvány
Ákos Pordán: **pordan.akos@kezenfogva.hu**
www.kezenfogva.hu

POLAND:
Polskie Stowarzyszenie na Rzecz Osób z Upośledzeniem Umysłowym Koło w Jarosławiu (PSOUU)
Anna Filipczak: **a.filipczak@dzwoni-jaroslaw.pl**
www.jaroslaw.psouu.org.pl

PORTUGAL:
CECD Mira Sintra
Carmen Duarte: **carmen.duarte@cecdmirasintra.org**
www.cecdmirasintra.org

UK:
Learning Disability Wales, in association with Cartrefi Cymru and Elite Supported Employment Agency
Jim Crowe: **jim.crowe@learningdisabilitywales.org.uk**
Jill Nicholson: **jill.nicholson@cartrefi.org**
Andrea Wayman: **awayman@elitesea.co.uk**
www. learningdisabilitywales.org.uk

Project participants from seven countries in Jarosław, Poland, on 10 September 2013.

Adapting services for persons with disabilities to new users

For more information please visit our website:

http://www.easpd.eu/en/content/adapting-services-persons-disabilities-new-users

Lifelong Learning Programme

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