

Leonardo Partnership N. 2012-1-FR1-LEO04-35551:
'Adapting services for persons with disabilities to new users'



Service providers' strategies to adapt services to new users
Compilation of all contributions

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Note to the reader: this summary report is based on information provided by the partners in the 'Adapting services for persons with disabilities_to new users' Leonardo project. While some are umbrella organisations for their sector at regional or national level, other respondents are individual service providers whose response is based primarily on the situation in their services. The analysis below should therefore be considered as primarily informative rather than fully representative of the situation in the participating countries.



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Austria

Introduction

This report includes the answers of a total of 7 organisations in Austria that gave feedback to a questionnaire that has been sent out in October 2013. In the questionnaire we asked the service providers to tell us what they think is crucial to adapt services to the needs of new users and which actions already have been undertaken.

1. Actions already undertaken

Involvement of service users and Person Centred Planning, Empowerment

During the last 10 years, service providers put an emphasis on direct involvement of service users. Service users are more and more involved when it comes to the design of services, they tell about their needs and through models like the Person Centred Planning or decision-making mechanisms for individuals who are unable to make personal, non-financial decisions for themselves the individual needs of service users are respected. Many service providers do also have user representatives or cooperate with self-advocacy groups.

It is quite important that service users recognize that they are active and talented persons, gain self-confidence and decide as much on their own as possible.

Multidisciplinary staff teams

Service providers that offered services either to persons with learning difficulties/intellectual disabilities or to persons with mental health problems had to change their teams. It was important to have experts in the field of mental health as well as experts in the field of disability within the teams. In addition, a closer cooperation with specialized services in the health sector has started but needs to be expanded.

New users are part of education and training in the social care sector but there is still enough room for improvement.

Use of social space

The social space model advises service providers to use the existing facilities of the neighbourhood (churches, public facilities, companies, schools, public cultural locations like theatres, etc.) and to overcome selective services for special target groups. Service providers therefore open up their facilities.

2. Strategies that service providers are lobbying for

Flexibility and Permeability

Service providers lobby for individual assessment of demands, a stronger person centred approach and flexible services that can be easily adapted to the needs of individuals. Persons with intellectual disability and persons with mental health problems often do have very different needs. Still it should be possible for service users to decide which services they want to choose.

In addition to that, it should be readily possible to switch between services if one service is more suitable than the other is. Flexible opening hours and smaller numbers of users within the services are important to improve the quality and flexibility of the services.

Personal budget

A personal budget is a sum of money that has been allocated to a disabled person, based on their needs. Direct payments do exist in Austria and many persons with disabilities use them to manage their own support needs. However, service providers are keen to extend choice and control to much wider groups of service users, including persons with intellectual disabilities or new users. This will create individual budgets, which will allow anyone with assessed needs to choose how they spend their budget to best suit them

Organisations

This report includes the answers from the following organisations:

Chance B Unternehmensgruppe

A-8200 Gleisdorf, Franz-Josef-Straße 3

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E-Mail: office@chanceb.at

Contact person: Helga Pintar (helga.pintar@chanceb.at)

The aim of the Chance B society is “to assist and support old, ill and disabled people so that they can go on living in their familiar surroundings and in this region, and live life to the full.” For this purpose, Chance B has worked out and set up service offers for people of any age to compensate for possible disadvantages due to disabilities in their efforts to pursue an independent way of life.

The Chance B–Sozialbetriebs-GmbH (Socio-Economic Company with limited Liability) runs an early childhood intervention service, an outpatient clinic (for physiotherapy, logopedics, occupational therapy, motopedics), a mobile assisted housing service, a mobile socio-psychiatric care service, a mobile home care and a mobile health care service.

The Gesellschaft für Arbeit und Bildung der Chance B GmbH (Society for Employment and Further Education of Chance B Ltd.) offers an extensive package of vocational integration measures, training courses and day care services. Job Allianz (Job Alliance) helps to improve the preconditions for job opportunities for people with disabilities in local and regional commercial enterprises.

The adult day care centre in Pischelsdorf is also used as an educational centre and accommodates 14 people with severe multiple disabilities who need round-the-clock care and support. The Hausmasters Dienstleistungs GmbH (The Caretaker Services Ltd.) all together employs more than 30 employees with disabilities and mental health problems.

Assisted Housing supports persons with intellectual disabilities whereas the mobile socio-psychiatric support focuses on persons with mental health problems.

Jugend am Werk Begleitung von Menschen mit Behinderung GmbH

A-1160 Vienna, Thaliastraße 85

Tel: 0043 1 405 02 86

E-Mail: office@jaw.at

Contact person: Ksenija Andelic (ksenija.andelic@jaw.at)

The "Jugend am Werk Begleitung von Menschen mit Behinderung GmbH" provides support to persons with intellectual or multiple disabilities as well as persons with mental health problems to enable them to live as independent as possible:

About 1.700 women and men with disabilities work at 23 workshops/day structures. Additionally, a number of workshops/day structures run projects that include earning basic qualifications. Together with several supported employment programmes like "Work Assistance", Job coaching" or "Integration Service" service users are supported to gain mainstream employment.

Three different housing models; "Accompanied Living", "Community Living" and "Residential Houses" are run to provide persons with disabilities with the personal support they need for an independent life. Appropriate service is also offered for the elderly and those with greater care requirement.

There is one housing service with part-time support that focuses only on the needs of persons with mental health problems.

LOK – Leben ohne Krankenhaus (lit. „Living without a hospital“)

A-1050 Vienna, Wehrgasse 26/11

Tel: 0043 1 586 56 46

E-Mail: lok@lok.at

Contact person: Christian Moritz (christian.moritz@lok.at)

The organisation LOK offers services to persons with intellectual disabilities as well as to persons with mental disabilities. Since January 2013, the organisation puts its strategic focus on persons with mental health problems.

LOK runs three occupational projects:

- LOK Couture (Second Hand Fashion)
- LOKal (Coffeeshop and Musicstore)
- Unverblümt LOK (Flower shop and Accessories)

The organisation also offers four local residential communities with 24h-support for persons with hospitalization effects, persons with mental health problems and persons with learning difficulties. Furthermore, there is a mobile support service (1-2 times per week) for persons with mental health problems and one support base for persons with mental health problems that live in their own flats nearby.

NÖ Hilfswerk

A-3100 St. Pölten, Ferstlergasse 4

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Hilfswerk is one of the largest organisations providing social & health care services, child care and support for families in Austria, as well as it supports people who need help in various regions all over the world. The NÖ Hilfswerk runs mobile early support services for children with intellectual disabilities and their families and offers psychotherapy at their service centres for persons with mental health problems till the age of 18.

VAB – Verein zur Schaffung alternativer Beschäftigungsmöglichkeiten für psychische Kranke

A-1070 Vienna, Neubaugasse 33/1/6

Tel: 0043 1 526 06 99

E-Mail: opus@gmx.at

Contact person: Maria Gasselseder

VAB runs occupational services that focus only on persons with mental health problems. There are no plans to open those services also to persons with disabilities.

Wiener Hilfswerk

A-1072 Vienna, Schottenfeldgasse 29

Tel: 0043 1 512 36 61 689

E-Mail: office@hilfswerk.at

Contact person: Angelika Linder (angelika.linder@wiener.hilfswerk.at)

Hilfswerk is one of the largest organisations providing social & health care services, child care and support for families in Austria, in addition it supports people who need help in various regions all over the world. The Wiener Hilfswerk runs the so called “Club 21”, a meeting point for persons with and without disabilities as well as persons with mental health problems. The Club 21 offers information about service providers and projects but its main focus lies on recreation and leisure time.

Wiener Sozialdienste Förderung und Begleitung GmbH

A-1150 Vienna, Camillo-Sitte-Gasse 6

Tel: 0043 1 981 21 3010

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Contact person: Gisela Kersting-Kristof (gisela.kersting-kristof@wiso.or.at)

Wiener Sozialdienste (Vienna Social Services) provides a diverse range of services including care, support, consulting and therapy facilities for elderly, ill, handicapped, socially challenged and socially vulnerable people and their families.

Furtherance and support (Förderung & Begleitung) offers individual support, integration and furtherance of children, youths and adults with disabilities:

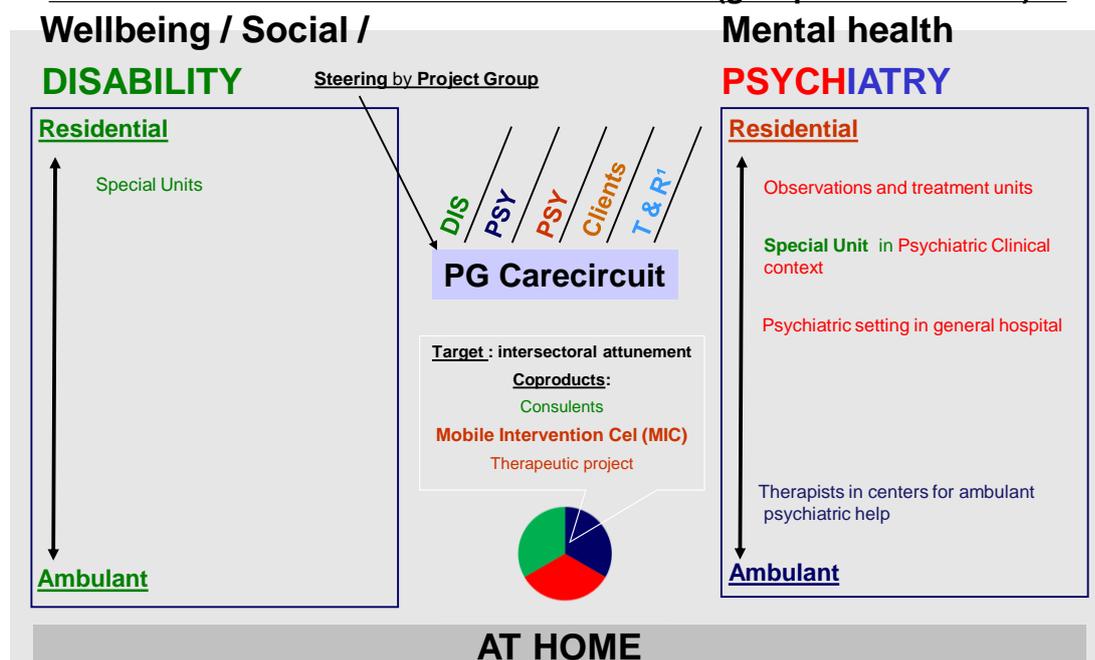
- Living – fully and partially supported
- HandWerk (Handicraft) – Structured daily schedule with retail shop
- Basic special needs classes
- Mobile early education
- Centre for promoting development

Belgium

1. An integrated model of care for people with an intellectual disability and a mental health problem (dual diagnosis – DD)

The model below was created by the Care Circuit of Flemish Brabant – Brussels¹ in 2002 and gradually applied there. Nowadays, many provinces in Belgium have applied or are applying similar models. It is, however, is not an official model, but gives an impression of the Belgian context.

A MODEL OF COMPREHENSIVE LINKING OF SERVICES FOR PEOPLE WITH ID AND MENTAL HEALTH PROBLEMS(groupe de travail DD)



The notion of 'dual diagnosis' particularly refers to the fact that persons with a disability and persons with mental health problems find themselves caught between two administrative sectors. In the Belgian context, this actually means three: welfare (including disability), certain mental health services which have been allocated to the communities and the supply of services for mental health which is still federal.

¹ « Plan directeur de circuit de soins pour adultes avec un handicap intellectuel et des problèmes de santé mentale (double diagnostic) » – Johan De Groef, Director of the not-for-profit organisation for people with intellectual disabilities 'Zonnelied', and President of the European Association on Mental Health in Intellectual Disability (MHID)

The starting point of the model is based on the principle of inclusion, i.e. people with an intellectual disability should refer as much as possible to mainstream services and only to specialised services when the mainstream does not suffice or cannot respond appropriately to the needs of the person. All starts at home, in a family. This should be the basis.

A project group was created to come to a coordinated supply of services, having an advisory role towards all services involved. Every province in Belgium now has such a project group, as it is important that care can be organised locally and close to the 'user' of the service. Also, every province has its specific way of working and can this way follow its own pace.

The role of the project group consists of coordinating all services involved at the respective level and to take any new or innovative initiative necessary to optimise co-operation or to extend a service.

There is no financing for the project group; per province they meet a few times a year. The consultants (therapists, psychologists ...) are financed by the organisation that employs them. Depending on the region, a few staff are paid by the regional authorities in charge of disability (e.g. in Flanders 2 FTE coordinators and 1,5 FTE therapists).

The project group consists of 5 groups of representatives:

- Representatives from the disability sector (assigned by the regional council in charge of disability)
- Representatives from the ambulant sector in the field of mental health
- Representatives of departments/psychiatric hospitals oriented towards people with a dual diagnosis
- Representatives of users
- Representatives from the academic world (faculty of medicine, psychiatry and orthopedagogics) and from corresponding training organisation.

1.1 Care Circuits

1.1.1 Key functions

The key functions of such care circuits/networks are:

- Activities on prevention and promotion of mental health care: detection, screening and diagnosis
- Ambulant intensive care teams for acute and chronic problems
- Rehabilitation teams who work on recovery and social inclusion
- Intensive residential care units for acute and chronic problems when an intake is necessary
- Specific types of housing where care can be offered when the home environment or alternative environment replacing home is not able to organise adequate care.

1.1.2 MICs (Mobile Intervention Cells; see model)

The goal of the pilot projects is to install a MIC for people with an intellectual disability AND a mental health problem WITH (the risk of) a (serious) behavioural problem. This MIC has as a general goal to make this behavioural problem disappear or at least reduce it.

The specific objectives of the pilots are:

- Improve the quality of life of people with an intellectual disability;
- Prevent stigmatisation of people with an intellectual disability by preventing them from being hospitalised (or reducing the frequency of hospitalisation), by avoiding emotional ruptures, by making sure there is a trusting environment and by avoiding the loss of pedagogic skills.
- Support professionals and families in their care for people with an intellectual disability.
- Enable and promote an adequate and qualitative approach within the life of a person with an intellectual disability.

The target group is every person with:

A mental health problem and

An intellectual disability and

A (serious) behavioural problem or a risk to a (serious) behavioural problem

The MIC's role is in secondary prevention (e.g. interpretation of the observed symptoms, identification of risk situations, etc.). The MIC advises the professionals and/or families during periods of crisis and tries to keep the persons in question in their natural environment.

The MIC also informs and trains professionals and/or families to increase their expertise (e.g. how to identify behavioural problems? How to recognise the indicators? What is the impact of medication? Who do we need to refer to?).

Beside the coaching role, the MIC is also in charge of observation, analysis of the behavioural disorder and of the context, elaborating on work hypotheses and work out an individualised intervention plan. The MIC should also give psycho-education to the patients. When needed, the MIC takes care of swift hospitalisation of patients and assures follow-up of the patient during and after their stay in hospital.

Finally, the MIC coordinates the treatment and guides and informs the patient during the whole intervention (role of case manager).

The MICS have already improved contact and co-operation for this target group within the care circuit and network in a relatively short time. They are ambassadors in inter-sector co-operation, especially between the disability sector and the sector of mental health. The specificity of the target group, their dependency on their environment as well as the fact that more sectors are involved, do not only justify the continued co-operation but also call for recognition and expertise.

Embedding all these teams in an inter-sector network, a care circuit, is important and offers the best possible guarantee for continuity of care for all involved. However, such an inter-sector network in the field can only function well if there is a good communication and understanding between the funding authorities.

In order to catch up with the number of requests for help and because generally intervention is needed for the client, family and professionals, staffing in the form of outreaching modules seems to be the most appropriate model. The number of staff is highly dependent on parameters such as availability, the size of the region and of the population.

2. Service providers in Belgium

When asking around amongst some service provider organisations for persons with disabilities in Belgium, we can say in general that, initially, their services were not tuned to the 'new users' (i.e. people with intellectual disabilities also experiencing mental health problems). Upon the arrival of the new users, the organisations were usually confronted with the impossibility of finding a place for them elsewhere, so they decided to take them in.

The service providers often offer more support to the 'new users' compared to the initial target group, but just as often staff has not been trained on how to approach this new target group and are just doing the best they can in the given circumstances.

On the other hand, the team will always take the time needed to devote themselves to the particular needs of each individual resident so also of those of new users. The service providers often work with one-on-one meetings with the individual and plenary meetings in a multi-disciplinary team to discuss more challenging 'cases'.

The following needs from service providers have been identified:

- Specific training for social workers and accompanists to address the particular needs of new users
- Funds to increase the number of accompanists and social workers to allow the organisation to be able to spend more time with each individual (specific funding for this target group?)
- Support from organisations/networks who know the challenges of addressing this target group and of making it part of their operational structure
- Support from organisations/networks to exchange practices on the methodology applied, on what works and what doesn't with regard to new users, on training etc.

France

Support

Objectives:

- Support persons with a double diagnostic or a mental disability while preserving the quality of support for all the supported persons, and while respecting the boundaries of what a social care service can do ;
- Promote inclusion, social and daily independence, and participation;
- Promote stability and maintaining the person in his/her usual environment; avoid ruptures when it is necessary for the person to go back and forth between the health sector and the social care sector;
- Avoid overmedication.

The framework:

- Community-based, scalable, pluralist and enhance services ;
- The setting must be enhance for each supported person. In order for cohabitation between these various types of disabilities to be successful, it must be acceptable for the persons. Gaps must not be too big, to avoid a negative mirror image.
- Fluidity of the person's path, promote links between various types of social care support, and between independent living and residential facilities (e.g. links between services, short stay in a residential facility, evening activities in a residential facility for persons living independently, etc.).

Methodology: person-centred responses with a holistic approach of the person, including:

- Person-centred planning at the core of the support;
- Proper holistic assessment, taking into account valuable expertise from all stakeholders (the person with disability, his/her family and close relatives, health professionals, social care sector professionals), entry procedure, and regular reviews to adapt the responses;
- The life story of each person is taken into account (previous work experience, education level, family life, marital life, ...);
- Good knowledge of the person ; observation of the mood fluctuations and sharing of information (transmission, team meetings) are established as constant professional practices in order to assess situations, to adapt support and to prevent crisis situations or withdrawals which are the signals of an unease (e.g. quiet moments are offered, activities can be stopped or changed, ...);
- Assessment of problematic behaviours, elaboration of individual protocols to deal with crisis situations.

Tools:

- Work on alternative and augmentative communication ;
- Bodies for the expression of users (working groups, users councils, ...): the persons can give their opinion on the support, and the support is adapted to meet their expectations and needs;

- Work around best practices recommendations published by independent bodies (national agency for the evaluation of social care services, national health authority), and internal and external evaluation of services;
- In sheltered workshops: working time arrangements, possibility to change activities with flexibility, review of the professional plan, possibility to include attendance of the medico-psychological support in the time dedicated to support.

Resources

Adapted location, architecture and furniture:

- Based in the community to foster inclusion, access to services and partnerships;
- Private spaces and spaces dedicated to quietness ;
- Small units ;
- Containing spaces.

Adaptation of human resources thanks to a sharing of resources (services are part of platforms):

- Multidisciplinary teams with paramedical and sometimes medical staff;
- A coordinator ;
- Facilitation of the links between various services (e.g. professionals working in two services to make transitions easier between services for the supported persons).

Team training – formal and non-formal learning:

- Several subject matters : psychopathologic disorders and the adequate support, behavioural disorders, Snoezelen, self-protection in the care environment, etc. ;
- Various tools : use of the employer’s obligation to train staff for group trainings (yearly association’s or service’s training plan), use of the employee individual right to training, access to qualification diploma, training or internship at the hospital;
- Elaboration of the training programmes with the grassroots workers: joint elaboration, action research;
- External trainers or speakers to help put things into perspective.

Team training –informal learning:

- Meetings to share and analyse practices, clinical meetings ;
- Transmission from professionals to professionals: within the multidisciplinary team (creation of a team experience by hiring persons with various profiles, meetings, role of the team psychiatrist/psychologist) and when meeting with external professionals (doctors, ...);
- Sharing of knowledge gained during trainings (presentations, sharing of sources, in-house library).

Support to teams (e.g. supervision, reflection groups) in order to avoid burn out and professional stress.

Support to the direction.

Funding:

- Looking for compromise between the funding rules' rigidity and a flexibility meeting the needs of users ;
- Use of systems allowing for block grants.

⇒ Anticipation is needed: the above mentioned aspects must be integrated into plans at the very beginning of the design of a service.

Partnerships

Work with a network of numerous partners for a holistic support:

Partnership with the health sector, especially psychiatric services. This partnership must respect the remit of each sector. It can take different forms, and ideally is formalized by a cooperation agreement – but not always. The various forms are:

- Referral towards the psychiatric sector for a follow up, for instance identifying this need during the needs assessment (cooperation is possible between the social care service and the psychiatric service to help the person accept the follow up);
- Better access to psychiatric consultations and care (in private practices, at public or private hospitals, or in the social care service – mobile unit) et to emergency general practices (partnership with a duty medical centre) ;
- Sharing of information for a better diagnosis, a better needs assessment and a better support ;
- Enable the person to be supported by a social care service rather than by the hospital when the support provided by the hospital is not adequate (for short stays or long-term stays) and preparation of the hospital discharge;
- Decentralisation: sharing of methods and exchange of practices, thanks to the sharing of staff (psychiatrist or psychologist working both for the hospital and the social care service), immersion placements (ideally with staff from the social care service going to the hospital and the other way round), access to training programmes and organisation of sessions of discussion.

Importance of the partnership with families.

Partnership with the local community (shops, services, associations ...) for a greater inclusion: awareness-raising about disability (and in particular mental disability), and sometimes mediation role.

Partnership with associations of persons with mental health problems and their families.

Governance

Support to new users must be enshrined in the strategic programme of the service provider.

Experimentation.

Hungary

The Hungarian social system

In the Hungarian provider system the (health and social) treatment of people with mental disability and mental sickness is fundamentally separated. The system is working according to the Act III/1999 which changed a lot since the law has come into force. Due to this there are some overlaps in the treatment forms of intellectual disabled and mentally sick people.

The state spends about 130 billion Hungarian Forints for relief each year. At the moment about 960 thousand people enjoy any kind of social and childcare treatment.

At the beginning (in 1993) food service, home support, daytime treatment of children and family service have been belonging to the **basic treatments** (obligatory for every local government) while nursing, rehabilitation and day care institutions, daytime shelters, temporary houses for children and homeless people, institutions for handicapped and visually impaired people have been **special treatments** (which belonged to the county local governments).

In 1998 the Act about the Rights of People with Disabilities has been adopted. According to the law, facilities providing long-term accommodation for disabled people must be converted to „humanised and modernised” residential homes until 1 January 2010 at the latest.

The treatment of disabled, mentally sick (and homeless) people got in the scope of basic treatments only in 2001.

This time started the „Fészek Program” (Nest Program) of Hand in Hand Foundation (between 1997 and 2002), with the following results:

- 41 Residential Homes for 500 people with intellectual disabilities, cumulative disabilities and autism, with the participation of 36 civil organisations
- Residential Home as an official institute got into the Social Law
- institutional lobby strengthened, which resulted financial supports by the state (for example a Residential Home building program with a budget of 2 billion Hungarian Forints, between 2000-2002)

In **2001** the treatment of local people with disabilities, people with psychiatric problems and homeless people got into the scope of basic treatments.

In **2003** the so-called **supporter service** appeared in the social provider system as a basic treatment task. From 2008 it is possible to gain financial support through tenders to ensure this kind of service.

The same year, home support with signalling device has been introduced while people with autism have been ranked to the scope of disabled people.

We have a system called „social employment” which has been introduced in 2006. From this year, also severely or cumulated disabled persons are allowed to move into a Residential Home, or rather go to daytime institutions. Between 2006 and 2008, eight Residential Homes have been built, as a consequence of a development program by „FSZK” (Fogyatékos Személyek Esélyegyenlőségéért Közhatalmú Nonprofit Kft. – Equal Opportunities of Persons with Disabilities non-profit Ltd.)

We faced a very important development in **2007**, when the **United Nations Convention on the Rights of Persons with Disabilities** was ratified in Hungary.

According to the Hungarian trends in social service and support providing system, the principle of indigency started to prevail more and more. With the assistance of ORSZI (Országos Rehabilitációs és Szociális Szakértői Intézet – National Institution for Rehabilitation and Social Profession) „nurture needs” have been measured and determined, taking into account one's financial situation, too.

In **2012** we faced a big change in the social system when the actuation and the maintenance of **all social and child care institutions have been replaced** from the county local governments **to the state** (Act CLIV/2011). It means that in case of different temporary and long-term accommodations for disabled and mentally sick people, the maintenance and the treatment coordination became also a commitment of the state. The maintenance and the methodology support are tasks of the Szociális és Gyermekvédelmi Főigazgatóság (Directorate General of Social and Child Care).

From the 1st January 2013 the service called „supported residency” has been started to operate, with more or less success. Its goal is to establish and organise a kind of treatment within the Residential Homes, work out its technical, personal and material requirements (See tender „TIOP-3.4.1. Ransom of Residential Institutions”, 2012-2015: ransoming 6 institutions).

Social treatments and services

Types of services

1. Social treatments:

Financial supports (for retired persons, residence maintenance, nursing fee, temporary aid, funeral aid, etc.)

In kind treatments (support for farming, public funeral, public medical treatment, health insurance, etc.)

2. Social services:

Basic services (caretaking in villages and farms, food service, home service, family support, signalling devices, public treatments, support service, outdoor social work, daytime treatment)

Special services (nursing institutions, rehabilitation institutions, temporary accommodations, Residential Homes, supported residency, other special social institutions)

Scope of „Personal care” = basic and special services

Rules for people with dual diagnosis

Within **basic services**, those families where disabled / mentally sick persons are living are entitled to have resort to the following services:

- Food Service: hot food at least one time daily
- Home Support: maximum 4 hours daily, in case of determined nurture need.
- Family Support: in case of social or mental problems, with signalling device, guidance for disabled and mentally sick persons, family-therapeutic and conflict handling mediational programs and services)
- Community Treatments: for psychiatric and addicted persons, support in independent life, ability development, continuous care about the condition of the client beside regular cooperation with the doctors, psychosocial rehabilitation, and therapeutic treatment)
- Supporter Service: in case of severely disabled and blind people
- 2007: Fecske Program (Fogyatékos Embereket nevelő Családok otthonában nyújtott időszakos Kísérés és Ellátás – Periodic Escort and Provision at Homes of Families Upbringing People with Disabilities). This service is offered by the Hand in Hand Foundation and help families in 180 stations countryside.
- Daytime Treatment: inter alia for mentally sick persons who do not need treatment in a medical institution

If someone cannot be supported in the frameworks of basic services, have to be treated through **special service**, or in special institutions like:

- Institutions offering medical attendance, nurturing:
 - 1.) Home for People with disabilities: require of accommodation is a medical investigation
 - 2.) Home for people with chronic psychiatric problems: for those who must not be in a medical institution, who are not dangerous for their environment and are not able the treat themselves even with support, and in case of personality disorder and addiction. Require of accommodation is official psychiatric expert's report (not older than 3 months)

- Rehabilitation Centres: help people develop abilities for independent life

1.) Rehabilitation Centre for People with disabilities: for people with intellectual disability, handicap or visually impaired persons. Education, training and rehabilitation. Prepare clients to return to familiar environment and their after-care system.

2.) Rehabilitation Centre for People with Psychiatric Problems: for adults who do not need any more acute or regular medical treatment and whose after-care cannot be done in another way. Offers training, work-like or therapeutic programs and prepares clients to return to familiar environment.

- Institutions offering temporary accommodation: ensures all-inclusive treatment for maximum one year. Types (beside places for elderly and homeless people etc.)

1.) Nurturer house for People with disabilities: for disabled people whose treatment cannot be ensured in the family.

2.) Temporary home for people with psychiatric problems: for mentally sick people whose treatment cannot be ensured in other institutions or at home, but do not need long-term institutional residence or treatment in medical institution.

- Residential Homes: receiving 8-12, or 14 mentally sick or disabled people (with autism, too), by treatment taking into account the client's age, health condition and self-care ability. For at least 16 years old persons whose rehabilitation cannot be ensured in his/her family and (at least partly) is able to care about him/herself.

1.) Residential Home for People with disabilities: with rehabilitational or nursing purpose

2.) Residential Home People with psychiatric problems: with rehabilitational purpose

How to access services of the institutions?

If someone wants to go to any social institutions, they have to make an application. The requests can be considered in many ways (by the local government represents board, by the director of the institution, by the court, the court of guardians...) and always in order of incoming requests. If someone's application was accepted, the parties sign an agreement which fixes the starting time of treatment, the time period of treatment, the content of services, the rules relating to determine and pay fees, the methods of stop treatment and the personal data of the treated person.

It is possible to apply to places out of turn in very reasonable cases.

Applicants need to show up expert opinions like: medical attendance opinion (for residential homes), expert opinions from rehabilitation board or medical evidences according to the type of disability, or papers proving financial support (for Daytime Care service), expert opinion about the existing of the psychiatric problem (for community treatment). In case of lack of expert opinion service can be ensured for the applicant for maximum 3 months after the handed in the requirement.

Persons have to pay a fee for Personal Care services, except those who do not have any income, or in case of residential home do not have any property underlying a mortgage. Some services (like family support, daytime care for homeless people, community treatment, outdoor social work, treatment at night refuges) are offered for free.

As we see, in the Hungarian system there is not any conscious strategy about the treatment of people with dual diagnosis, the providers handle the two types separated, although there are some overlaps in the treatment forms.

Strategy for providing good quality care for persons living with dual diagnosis

The Hungarian social care system is clearly divided by target groups and was built up to provide care for different target groups, and it's principal to check the diagnosis when someone would like to enter the service provider. In Hungary is it impossible that a person who holds some kind of mentally ill diagnosis get social care from a service provider which is entitled to provide services for disabled persons. Literally that would mean persons with dual diagnosis won't find suitable care. Practically it means the examiner staff or the person itself should choose the target group he/she would fit in more, or her/his the leading diagnosis. In that situation it is really hard to say or to find a service which is worth mentioning as a best practice.

What we see commonly is that the services that are providing care for the two referred target groups are building up good cooperation, and they regularly hold meetings, and they exchange their experiences, or try to build a strong professional connection between staff members. The staff members are exchanging advices and good practices as well. But we should also see that it is not happening within formalized agreements. It is a big lack of the professional work because written down best or good practice is not available, and the cooperation are depend on the geographical locations (the closer the services are to each other, the higher probability they will cooperate), acquaintanceship of the staff members.

Poland

The primary strategy in order to adapt services to new users was creating the sector of double diagnosis, which aims at searching for new solutions which enable choosing such available services and solutions so that intellectually disabled people with mental illnesses can be optimally supported.

The double diagnosis sector consists of workers of all of the facilities of the Polish Association for Persons with Intellectual Disabilities Chapter in Jarosław (PSOUU). This makes it possible to support new users on every level of functioning (education, environmental support, vocational training, vocational activity, living etc.).

Hitherto prevailing actions included the following areas:

- Bringing to life multidisciplinary, multi- institutional/facility groups in order to support certain people.
- Building a chain of connections between social welfare facilities, psychiatric hospitals and other facilities which support people with mental illnesses or double diagnoses, and the Association.
- Introducing changes in the certification system
- Training for different groups of recipients (including supervision)

Bringing to life multidisciplinary, multi- institutional/facility groups in order to support certain people

Teams aiming at complex study of the way of supporting a given person (new user) have been introduced. Because of the difficulties encountered by teams of one specific supporting facility (the teams consisting of specialists who have thus far taken care only of intellectually disabled people), have been expanded by people who are experts in specific fields (e.g. a person suffering from Prader-Willi syndrome, diabetes and aggressive behaviours, has been put under the care and support of people who have had training in substituting aggressive behaviours). This person has also been consulted by diabetes and psychiatric experts, which made it possible to choose the right medication and eliminate some behaviours.

Every manager of a given facility can ask expert workers of other facilities of the Association, for a consultation, which in turn makes better support for participants, possible. It also enables the use of the working teams' potential in the direction of supporting new users.

A significant example of multidisciplinary teamwork in the work sector is employing (due to innovative appliance of regulations concerning employment) completely incapacitated people with double diagnoses.

The multi- reasoned necessity of complex support has been noted (e.g. aggression of a participant may be caused by different factors- it doesn't not always have to derive from a mental illness, the reason may lay in e.g. hormonal disturbances). Despite widely and comprehensively trained staff, the human resources of the PSOUU are not always enough and that is why it is important to create a chain of connections between institutions who also support new beneficiaries.

Building a chain of connections between social welfare facilities, psychiatric hospitals and other facilities which support people with mental illnesses or double diagnoses, and the Association

PSOUU Chapter in Jarosław has undertaken the following actions concerning the sector of double diagnosis:

- establishing cooperation with the Regional Support Facility, which provides help to people who suffer from psychological problems (consultations, therapy, family support- supplementing the offers of the facilities whose participants are new users).
- cooperation with chosen social welfare facilities (providing financial support for the poor, organizing meals, assigning the support of psychiatric nurses to certain people – meeting and ensuring the primary needs often helps new users to function better in a facility).
- consultations in chosen psychiatric hospitals (expanding knowledge in psychiatry, by people who have thus far been working with the intellectually disabled, possibility to cooperate with a so-called 'mobile team', which can constantly support new users in the chosen aspects of their functioning, expanding the awareness of psychiatrists when it comes to supporting new users- a meeting in the Specialist Psychiatric Health Care Team in Jarosław, scheduled for December).
- planned participation in the Podkarpackie Psychiatric and Welfare Care Forum (touching upon the notion of people with double diagnoses and mental illnesses in the existing support system, in the context of the National Programme of Mental Health Protection, searching for new networks of connections).
- possibility of cooperation with the aforementioned institutions in certain EU projects, which aim at supporting new users.

It has to be stated that not many initiatives come from the aforementioned institutions. They are mostly passive and they approach changes with little versatility (with some exceptions).

Introducing changes in the certification system

The work here will consist in:

- working with the parent of a person with a double diagnosis or a mental illness consisting in making them aware of the procedure connected with filling out documents needed to be put forward before the medical commission, as soon as possible (complex documentation, suitable description of support needs –repeatedly, not choosing one of the points makes it impossible for new users to benefit from e.g. environmental support system- this results from low awareness of the parents about the process of certification).)
- cooperation with disability certificating teams – workers of the certificating teams encouraging to gather complex documentation and educating about how to properly fill out required documents.
- promotional – informative campaigns of PSOUU facilities planned in Rehabilitation, Education and Development Centre/ Non Public Vocational Preparation School (education concerning the proper way of filling out documents- so that there are no questions as to what disability we are dealing with, what kind of support does the person need, what facilitates later work and the proper adjustment of support).

Training for different groups of recipients (including supervision)

After having diagnosed the needs deriving from supporting new users, new training for many different groups, have been carried out (new users, staff, parents, etc.). The training is organized by:

External companies:

- training concerning the sexuality of disabled people (a series of trainings for the staff, planning trainings for persons with disabilities and their parents)
- submitted need of training concerning psychiatric knowledge (addictions: alcoholism, shopoholism, schizophrenia) and family therapy – supervisions carried out in the Rehabilitation, Education and Development Centre by a long term specialist who deals with supporting youngsters with intellectual disabilities, double diagnoses and mental illnesses (registering difficult behaviors, analyzing recordings, working out plans of working with a given person).

PSOUU staff (creating a database of potential trainers, PSOUU workers from a given area of expertise):

- training and supervision about aggression substitution training
- training concerning supported employment of new users
- training for parents e.g. supporting independence

Portugal

This document aims to present the **strategies** used by CAAAPD Service in CEERDL - located in Caldas da Rainha.

CEERDL is a social solidarity cooperative, founded in 1977 by a group of parents to meet the needs of local young people with special educational needs. At first, it was the support of people with special educational needs in school and, then developed to a broader universe of intervention that beyond mere education is vocational training, employment, health and home support.

The organization has been expanding its services due to the growth process and the new needs of these young people who reached adulthood and whose parents aged and fail to provide them the necessary care beyond themselves need additional care cause of their own aging.

CEERDL is guided by the principle of "working with and for its clients", by implementing an innovative methodology that involves clients and their families in the phases of design, monitoring and evaluation of individual plans. It is noteworthy, also, the needs assessment and local planning and building services in response to identified needs, as well as their evaluation with the participation of its significance, if the former cannot do so. Promote an intervention that covers the social and professional integration, ensuring internally or through partnerships with various social services, from health to education, through work and leisure.

CAAAPD is a social response overseen by Social Security. It provides a framework of support for citizens with disabilities (disabilities and mental illness and dual diagnosis), mainly without other institutional support and entered the community. Provides information about rights and accessibility, mediates the interaction with other services and promotes autonomy and skills development aimed at improving psychosocial condition and social participation. It receives annually 60 users on average.

It aims to intervene with a holistic and community approach, so that citizens with disabilities and their families have at their disposal a personalized multi-dimensional service, focusing on their participation. It responds to needs identified by the network of local partners in providing support in solving specific problems of people with disabilities, preventing exclusion and promoting access to rights.

The target audience is composed by individuals who are referred by the community (entities, partners) or by individuals (including by other customers). It covers all age groups, sex and any citizen regardless disabilities.

Diagnosis is followed by developing personalized care, directed towards improving the quality of life of people with disabilities and their families; Evaluation of needs and expectations, potential, abilities and skills, and the enablers and barriers to participation. Counselling and assistance in many situations of life path, with a view to their social and ultimate aim is subjective well-being of the person.

Intervention Strategies and Methodology

- The approach and intervention is based on a community and participatory model;
- It has been developing over 17 years , in a way that favoured the participation and involvement of various organizations and community stakeholders in building a network of care and monitoring to users ;
- They constructed a model of care closer to the people, tailored to their needs and promoting their quality of life and rights of citizenship;
- Person centred methodology;
- They value customer engagement, family and significant individual plan of care and rehabilitation, promoting factor adherence to intervention strategies and greater success in the intervention;
- Even when referred by another service is the person that is requesting support and presents its needs in accordance with its expectations.

The framework consists of:

- Dynamic model and networking;
- Coordination of existing services in the community promoting a great co -responsibility of the technicians involved;
- Trans-disciplinarily as a guarantee of consistency and monitoring the individual plan of action;
- Accessibility, in the view of the user;
- Monetization of community resources (physical, human and material) that may directly or indirectly involved in the rehabilitation process;
- Prevention and early detection of problem situations as well as of barriers to participation.

CAAAPD's Intervention is structured in the following 5 phases:

- **PHASE 1** - Brief presentation of the case and needs identified by the professional/ referral entity versus needs identified by the user.
 - **PHASE 1.1** - Summary Presentation of customer service, entity framework and understanding of the service.
 - **PHASE 1.2** - Summary Presentation of customer service, entity framework and process opening.

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- **PHASE 2** - Reflection with the user and Identification of Areas of Needs (Diagnostic and intervention needs Individual Plan of Intervention)
- **PHASE 3** - Support , guidance on the definition of Intervention Strategies Subsidiary
- **PHASE 4** - Routing and Monitoring
- **PHASE 5** - Monitoring and Follow up

User's characterization and their needs characterization are essential for allowing understanding of behaviours, attitudes and expectations that define their personal way of being and living. The path of life and its environment requires from the user a reflection and awareness of the various roles and functions (in and of) society. Their relationships and social attitudes are still featured by the existence of alternative forms of occupation and distractions and the activities of leisure revealing interests and motivations. User's educational, training and professional background complements their characterization and allows comparing expectations with acquired knowledge and skills developed.

After the diagnosis of needs for intervention and intervention areas identified by the user and professional comes a phase to verify users predisposition to act in order to achieve the satisfaction of need identified. After confirming this step, a draft of the Individual plan is made and at same time user and professional awareness is enhanced on the advantages and disadvantages of the strategies chosen.

The plan is then monitored to evaluate differences with what have been planned and assess the steps elapsed, and (re) consider next steps. This procedure is made by user and professional.

Wales

1. Responsibility for providing social care and health care services

In Wales the responsibility for determining national social care and healthcare policies rests with the National Assembly and the Welsh Government. The development and delivery of all social care services for children, young people and adults with a learning disability is the responsibility of 22 local authorities. They perform 2 key tasks. They assess an individual's needs and their eligibility to use services. Secondly, they act as commissioners of those services, either directly delivering them, or commissioning them from non governmental organisations or 'for profit' organisations. An increasing proportion of services are being commissioned in this way.

Most health services are managed and directly delivered by an agency of the Welsh Government: the National Health Service, Wales, through 7 Local Health Boards.

2. Definition of learning disability

In Wales, by 'learning disability' we mean individuals who from birth or early childhood will have had an impairment of intellectual function that significantly affects their development and leads to difficulties in understanding and using information, learning new skills and managing to live independently.

3. Welsh Government Policy for Adults

In the early 1980's a succession of media revelations about shocking abuse of residents living in what were called mental handicap hospitals embarrassed central government into action. The result was a revolutionary policy commitment, the All Wales Mental Handicap Strategy. Launched in 1983, the policy had 3 simple principles. People with a learning disability have the right to:

- an ordinary pattern of life within the community
- be treated as an individual
- additional help and support in developing their maximum potential.

The Government made a commitment to establish new patterns of community services, to close the institutions, to begin to listen to what the individual themselves wanted in life and to provide substantial additional funding.

Though the wording of the principles and the detail of policy has been refined and adapted in the intervening years, they remain at the core of Welsh Government policy and have helped shape all subsequent social care policy in the United Kingdom.

Community services have developed that assist the individual with a learning disability on where and how to live, work and leisure, relationships and staying fit and healthy.

A steadily increasing expectation has been placed on agencies to encourage and assist the individual with a learning disability to express their wishes using whatever communication method suits them and for agencies to pay heed and respond appropriately. The legitimacy of advocacy in assisting this process has also increasingly been acknowledged.

4. Welsh Government priorities

Across all the relevant national policy documents a number of themes can be identified as either implicit or explicit priorities that will benefit people with a learning disability. Many of these were brought together in proposals in 2013 by the Welsh Government for a new Social Services Act. The chief priorities over the next ten years for Welsh services to adults are:

- **Right to Person centred planning**
Commissioners of social care are expected to work alongside the individual with a learning disability, developing a person centred plan that truly reflects their wishes and needs, to engage the individual in identifying and making choices and tailoring services that meet those needs.
- **Vocational training**
For people aged 16+ further education colleges make learning opportunities available to people with a learning disability. Courses offered can be about life skills, like learning to be more independent or be more vocational, like learning to work in a hairdressers or gain food hygiene qualifications. Steps are being taken to ensure that any proposed course really is tailored to the needs of the individual and will be useful.

Some n.g.o.'s and social enterprises also exist that try to boost the skills of the individual. Activities vary. These include woodwork workshops that make products for sale, cafes, shops that make and deliver buffet meals and sandwiches, gardening and waste recycling teams and second hand furniture restoration and sale. The individuals are deemed to be trainees, so that while they do not usually get a real wage they may get a training allowance and will continue to be entitled to unemployment or disability welfare benefits. Funding for these services is fragile, coming from a number of sources.

- **Meaningful day opportunities and getting a job**
There is no statutory responsibility on Welsh local authorities to help people get jobs. However policy guidance tells social service commissioners they should provide constructive opportunities for people with a learning disability during the usual working week. As a minimum, most individuals will be given an opportunity to attend a day centre. Activities at these centres vary, but will often include participation in arts, crafts or drama classes, learning how to care for and grow plants or some vocational training. Often based in industrial-type units, the service will be segregated.

In some areas, local authorities will fund a supported employment agency, usually an n.g.o., to help an individual become work-ready, to job search for them and to job coach them when they are employed. The agencies usually seek 'real wages for real jobs.'

- **Direct payments/ Individual budgets**

The political party controlling the Welsh Government is opposed to a pure market model with the individual buying their own social care. It wants to ensure that local authorities continue to have a responsibility and a duty of care to all individuals who need social care. It rejects any commissioning model for social care that gives an individual a personal budget and then steps back, not monitoring the care received. The Government has stated that they will encourage more direct payments, or personal budgets, but only where the responsibilities of social care commissioners are maintained.

- **Mental capacity and advocacy**

All individuals with a learning disability are believed by government legislation to have mental capacity to take decisions unless professionals can demonstrate this is not the case. Where mental capacity is concluded to be variable or to fluctuate in regard to key decisions, particularly where the individual also has a mental health condition, they will be provided with an advocate for a time-limited period to represent their best interests.

- **Challenging behaviour**

Health and social care agencies have not always been very good at being pro-active in identifying and responding to the needs of individuals who may challenge services. Between 12-17% of people with learning disabilities display behaviours that challenge.

High cost services that do little more than physically contain the individual, congregate the individual with other people exhibiting the same behaviours and are not compatible with the All Wales Strategy are sometimes commissioned out of desperation at a point of crisis. WG is asking agencies to collaborate more effectively, plan ahead and try to commission more purposeful services.

The policy rationale is that individually tailored, expert interventions delivered by local community services which do not remove the individual from the people and surroundings that are familiar to them will be far more successful than placing the individual many kilometres away in a new, strange environment.

- **Access to mental health services**

A feature of generic adult mental health services has been that it has been difficult for people with a learning disability to get help from these professionals. Psychiatrists in these services have tended to argue that individuals with a learning disability who also have a mental health problem need to be helped by medics who specialize in learning disability and mental health. As this skill mix is rare, individuals frequently lack proper medical assistance. The Welsh Government is trying to improve access by insisting that general children's and adults psychiatric services should not discriminate against, and refuse help to people with a learning disability.

- **Families with complex needs**

WG has given social service departments funding to establish Integrated Family Support teams of social workers and social care staff to support families with complex needs, including those with children who have complex needs or challenge services. This a response to a belief that there are some families that may face a range of complex difficulties that impact upon each other and make overcoming each factor in isolation very difficult.

5. Attitude toward adapting services to new users

There has been no particular drive at national and/or local levels in Wales to directly push learning disability service providers to adapt their services to new users. What has occurred has been an increasing emphasis placed on encouraging commissioners and providers to use person centred techniques to identify an individuals needs and to provide a personalised service response. As this approach has developed, it has become apparent that the needs of some individuals have not been very effectively met: in particular people with a learning disability who have mental health difficulties, people with a learning disability who are on the autistic spectrum and people with a learning disability who are coping with dementia.

Provider organisations have had freedom to expand their services to new users if they decide that this is a way that they wish to develop their organisation. In this sense there is a market in the provision of services and a sensible provider will assess whether changing their service orientation or expanding their services is feasible and desirable. The quality of commissioning practice varies across local authorities, but a good commissioner will not pay for an existing service to meet the needs of a new user unless they are happy that doing so fits with their commissioning plan and represents good value. As in the purchase of all services, the buyer will decide whether to buy based on assessing the relative cost and the relative quality of the product.

Of course there will always be an exception to such good practice: where a commissioner needs an urgent solution to support a particular individual, say with a mental health condition as well as a learning disability where there is no existing service and there are spaces in an established learning disability specific service.

Good quality commissioners and providers will demonstrate a commitment to several features. These will include:

- Using a person centred approach where the service user can exercise choice and control
- An emphasis upon multi- disciplinary and multi- agency working
- Working closely with other key stakeholders
- Ensuring that services are community based and encourage social inclusion

If providers decide to expand or adapt their existing service they will make an assessment of whether this is a sensible step. The assessment will determine whether the principles and values of their service need to be adapted, whether the experience and training of their staff is appropriate and what may be the cost of changing the mix of their staff, both financial and in terms of morale and stress for the staff team.