TRAINING FOR INCLUSION OF AGEING PEOPLE WITH DISABILITES THROUGH EXCHANGE

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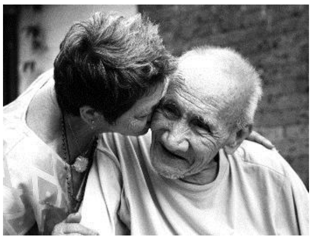
FINAL REPORT

INCLUSIVE SUPPORT OF AGEING PEOPLE WITH A DISABILITY

SUGGESTIONS FOR FUTURE ACTIONS



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1. INTRODUCTION

After in depth discussions for a longer period of time during the activities of the Disability and the Elderly working groups of the ENSA[1] network, and with the support of KCSE[2], 10 European organizations established a *learning network* to share organizational and educational policies and practices, as well as defining critical factors of success in supporting ageing people with a disability in an inclusive way.

All partners believe that community based support and opportunities for living in an inclusive society with equal rights for everyone, contribute to the wellbeing of all citizens. A general and, initially, a rather implicit ‘good practice vision’ of the partnership was built around the client, his perspective and his potential active contribution to society, being part of it as a full citizen. Within this ‘vision’ we stress on specific principles and goals. According to us, professional support is always residual – stressing on the key role of the social network and mainstream services. The professional involved not only ‘supports’ and ‘cares’, but also empowers the client, his network and mainstream services. A holistic approach seemed to be a key factor of success. The professional, working together with all citizens, local and national policy makers, sensitizes the environment and contributes to the accessibility (not only physically) of the environment, encouraging tolerance.

At the very beginning of the project period, some partners were implementing inclusive practices successfully, while others were defining new policies and/or strategic goals or were setting the first moves to implement a new policy. Some partners are closely linked to research, education, organization development and support. Both, small organizations and organizations covering bigger regions were involved. Services for the elderly, services supporting people with a disability and organizations active in both fields are part of the TRIADE group.

Supported by the European Community (within the Erasmus+-framework), the partnership could work together intensively for 26 months, from September 2015 onwards. International meetings, always focusing on a specific item of inclusive support of ageing people with a disability, created opportunities for the participants to learn from each other by actively reflecting on innovative or challenging local, regional or national policies and practices. Local Expert Groups – established (at least one) in each country with representatives of other organizations active within the same or different field, universities, public bodies,… – served as an extension of the mere partnership, by giving additional feedback on the practices and their significance for local or national challenges and by giving input to recommendations for policy makers on all levels and for education. Five TRIADE-newsletters gave many stakeholders insight as to how the project was progressing.

As the project was developing, a limited number of themes (see chapter 3.) were running as common threads through the reflections on the practices, independent the specific content or focus of these practices. It was surprising – or not!? – to see that these themes are not exclusive themes and are not only linked to people with a disability, but are meaningful for all citizens.

This partnership is a learning network, aiming to learn and reflect, and to share these reflections with stakeholders (policy and education). Chapter 4 summarizes these reflections.

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[1] ENSA – European Netwok of Social Authorities - http://www.ensa-network.eu

[2] KCSE – Knowledge Center Social Europe – KennisCentrum Sociaal Europa – Brussels - http://www.kcse.eu/

2. THE TRIADE PROJECT – STARTING POINTS

2.1. New needs to deal with

Society is challenged by a growing number of ageing people. This is true for all ageing people, also for people with a disability who are supported by service providers in different ways (residentially, ambulatory at home, …). By consequence, personnel/staff is invited to develop new skills in order to cope with the changing needs of the clients and in order to enhance Quality of Life of the elderly.

2.2. Inclusion

At the same time service providers, organisations and the whole society are expected to make the transition to effective community based services – accessible for all. This is part of the positive evolution towards an inclusive society and the paradigm shift towards a social model of support, full and active citizenship, etc. This refers to the UN convention on the rights of people with a disability, obliging nations to develop and implement an inclusive policy!

For services: the range of professions and roles, skills and attitudes required will be different during and after this transition. But also, this transition gives a significant – new - role to mainstream services and to informal caregivers – both to be supported, and by doing so, giving an additional new role to professionals.

2.3. Ageing in place as an inclusive principle

Actually the ‘ageing in place principle’ is a leading inclusive principle: according to this principle, the elderly – if this is his or her choice – must be supported in the place where he or she wishes to become old. When this is not possible anymore (due to e.g. needs that transcend the competencies and means of the service provider), transfer of people with disabilities to the regular service for the elderly, including a qualitative support, must be possible.

It is often heard that professional staff is actually missing the right skills/attitude to guarantee the best support of ageing people (with disabilities). There is a need to re-skill and up-skill: new competencies related to new needs of ‘new’ clients[3] are needed. A transition from a medical to a social inclusive mind set needs to be made, referring to other beliefs, attitudes and inclusion oriented skills. Special challenges are related to the motivation of the staff to work with a new and other target group than the group they initially have chosen for to work with; new and more complex tasks related to physical, emotional, social ànd mental needs of the elderly need to be done. Professionals in services for the elderly and for persons with disabilities, will be asked to look beyond their own responsibility and to pay attention to the needs of mainstream services, volunteers, informal caregivers, etc.

The TRIADE partners wanted to share policies, methodologies and practices that show evidence of an inclusive support of ageing people (with disabilities), and to define those factors that are critical for a successful inclusive support. Between others, the partners strongly believe that a good collaboration between the fields involved make a significant difference in creating more competent staff. Services

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[3] This group of clients are largely invisible in European strategies like Europe 2020 and Horizon 2020.

for the elderly, need to learn how to care for/support ageing people, also when they have a disability: staff needs to acquire new, additional skills related to the needs of people with disabilities. At the same time, services supporting people with a disability need to acquire skills in order to create opportunities for the elderly (with a disability) to age at the place of their choice for as long as they wish and are able to. These services need to acquire new skills, related to 'ageing'. In this matter, exchange is a key word.

In addition to all items mentioned in this chapter, and although everyone - solidary - contributes to social security systems that (should) guarantee support when a citizen needs support, there is an additional need/transition towards citizens to take part in caring for each other, not only because the number of ageing people grows and the financial means are limited, but also to move (again) towards a more inclusive society and community based support. This creates an opportunity and necessity to provide a platform for knowledge exchange and to create collaboration between professionals, clients and informal caregivers (family, neighbours and volunteers).

3. TRIADE-THEMES

While reflecting on the policies, methodologies and practices that each partner shared, four themes were significantly present – giving an overview of our lessons learned: Quality of Life as central concept; the 'new' professional to indicate new roles, skills and attitudes; informal care as part of 'community based' support; and 'Ageism', linked to actions to valorise the elderly. These themes are different from each other and equal at the same time, as they are closely interrelated.

3.1. Quality of Life – QOL

3.1.1. Inclusion and quality of life: two of a kind?

Since the period following the Second World War, there is a broad consensus that all people should enjoy the same civil and human rights, as represented in the International Human Rights Law (1948) and the United Nations Convention on the Rights of People with Disabilities (2006). Countries that ratified the UN convention endorse the full inclusion and participation of their citizens, irrespective of their age and type or onset of their disability. They also agree that personal autonomy, empowerment and free choice are essential elements for inclusion. This suggests that all persons should have the ability to realize their full potential, from the cradle to the grave, and to take their lives into their own hands.

At the same time, the increased longevity of people worldwide raises the question of how to ensure social inclusion of an ever-growing number of older people (Bigby, 2002; Weber & Wolfmayr, 2006). This issue is also reflected within the TRIADE project, which aims to look for good practices that enable or endorse the inclusion of ageing persons – and, more specifically, ageing people with a disability – with the intent to describe recommendations for policy and VET (Vocational education and training). Current political attempts to realize an inclusive society have already been combined with various concepts – such as 'active ageing', 'ageing in place' or 'age-friendly cities' – and indicated by the plea for community care, deinstitutionalisation, inclusive healthcare facilities and general nursing homes (Amado et al., 2013).

However, despite the prominent use of the term *inclusion* in recent policy and practice, various scholars argued that the concept gets more and more "troubled by the multiplicity of meanings that lurk within the discourses that surround and carry it" (Graham & Slee, 2008: 83). This compels us to critically revise current references to inclusion and to reflect on what exactly is intended and to whose advantage.

For instance, different authors have warned against the use of inclusion as an instrument of social policy (Lister, 1998; Slee & Allan, 2001). They argue that in a context of increasing welfare cuts and marketization, the rhetoric of inclusion risks to mask dwindling politics of care (Lloyd et al., 2014; Martin, 2013). Furthermore, with regard to the present discourse concerning older people with disabilities, we might wonder whether the aim is purely to include them or rather to be inclusive. Do we seek to confine inclusion to the physical incorporation of individuals and groups within the existing social order or (elderly) services? Under conditions that are defined beforehand? Which again risks to induce the exclusion of people who do not seem 'to fit', according to these criteria? Or is it our purpose to be inclusive, and to realize a more equal society, in which the right to human flourishing is guaranteed for every citizen (Dean, 2010)? The latter entails that we cannot simply 'include' distinct categories of people into fixed structures and provide them with compensatory or remedial models of support (Lloyd, 2008). It rather urges us to perceive inclusion as an ongoing process of deconstructing and reconstructing the outlines of support, while continuously exploring the life worlds and meaning making of the people involved.

If the Triade-project aims to favour the second approach, we argue that the link between inclusion and people's right to quality of life must again be made explicit in the assessment of 'good' practices. Therefore, in what follows we present the concept of Quality of Life (QOL) as a common frame of reference which can help us to explore and analyse existing initiatives in very diverse contexts, considering the state of service development, structures, procedures, social policy and politics of inclusion.

3.1.2. Defining Quality of Life

The past few decades, public awareness and research into the Quality of Life (QOL) of people with a disability and ageing people has been growing. In both fields (e.g. disability and ageing), QOL is recognized as an important process indicator and outcome measure for assessing the effectiveness of treatment (Schalock & Verdugo, 2002). However, when browsing through the existing literature, we notice that QOL can be conceptualised in many different ways. Some perceive QOL as Health Related QOL (HRQOL) while others have a more holistic view. In the case of HRQOL, the focus is on how a specific disease or illness effects the daily functioning of an individual, especially the physical and mental health of the individual. The emphasis here is on pathology and deficits. With regard to the holistic perception of QOL, health is an essential subdomain of QOL but does not cover the entire QOL concept, starting from a more positive connotation, and emphasizing the overall wellbeing and satisfaction of the individual. While both views are observed in the literature, there is a slight overweight for HRQOL in the ageing field. This is not surprising as ageing is often associated with negative connotations, such as a decline in health and cognitive abilities, inactivity, increased dependency and social isolation. Contrarily, issues related to people's disabilities are to a larger extent treated from a citizenship perspective. This is a model that focuses on possibilities, individual capacities, personal autonomy, and social inclusion issues.

With respect to ageing people with a disability, the literature on QOL remains rather limited. In 1989 Roy Brown wrote an article on "Ageing, disability and quality of life: A challenge for society". Since that time the relation between QOL and ageing people with a disability has occasionally been mentioned during disability conferences and in supplements of international journals on disability. The few studies available on the QOL of ageing people with a disability are either health related (HRQOL) or focus on the impact of the living situation (i.e. community living, supported housing, living independently,…) on the individual's QOL.

Despite the fact that QOL is becoming more and more a central concept in the practice models for people with a disability and maybe to a lesser extent for ageing people, there is no consensus on how to define QOL. We do notice however that within health care, the definition of the World Health Organisation (1995) has received increasingly more attention. WHO defines QOL as "an individual's perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept, affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment" (WHOQOL Group, 1995, p. 1404).

Within the disabilities field Schalock, Keith, Verdugo and Gómez (2002, p. 21) define QOL as: "a multidimensional phenomenon composed of core domains influenced by personal characteristics and environmental factors. These core domains are the same for all people, although they may vary individually in relative value and importance. Assessment of QOL domains is based on culturally sensitive indicators"

Both definitions clearly identify the multidimensionality of the concept. Within the disabilities field, QOL is predominantly operationalised by eight domains, including: personal development, self-determination, interpersonal relationships, social inclusion, rights, emotional, physical and material wellbeing (Schalock & Verdugo, 2002). Within the ageing field, studies are influenced by the WHO group and despite the focus on health related indicators, they also look at how these indicators might influence life domains such as psychological, social, functional and sometimes spiritual well-being.

In addition, QOL is first and foremost a subjective concept. Although QOL is defined by both objective (e.g. having a payed job) and subjective indicators (i.e. satisfaction about the job), they are not always coherent (Cummins, 2000); A person can have a payed job but be unhappy with the circumstances they have to work in. It goes without saying that a person's basic needs are important and need to be fulfilled. But QOL is more than that: it reflects an individual's perspective on life (Cummins, 2000), their values, attitudes, aspirations and experiences.

QOL is not a static entity that remains unchanged during the course of life but rather a dynamic concept that transforms with age, influenced by a person's dreams, expectations and aspirations (Carr et al., 2001). It also implies that with the right support, a person's QOL can be improved.

Finally, according to Schalock et al. (2007), QOL is also a universal concept; some domains are common for all people irrespective of their culture, problems or gender. Yet, the value, interpretation and importance that is given to a specific domain may vary largely between individuals and cultures.

3.1.3. What is the value of the QOL concept in working with ageing people with a disability?

When a person ages, it is not surprising when the individual reports more need for personal care and a decrease in functional or cognitive abilities. In such situations, it is essential to properly address these newly emerging care needs. However, when meeting these health care needs it should not come at the expense of other important life domains. For example, studies have shown how physical, medical and health-related issues are the main concern of staff supporting ageing people with (intellectual) disabilities. They express the need for more training and greater knowledge on these particular issues so they can support their ageing client group more effectively (Wark et al., 2014). In this context, knowing how to activate or include ageing clients with a disability is often considered less important. This is because care workers assume that it is part of the natural ageing process, older people lead more sedentary lives, go out less compared to younger people, and have fewer friends (Walker & Walker, 1998). However, to the extent that older people with a disability become more dependent, inactive and socially isolated, it is clear that this is not a result of choice but is one of the aspects of their lives that they would most want to change (Wark et al., 2014). To counterbalance the tendency of service providers to 'take care of' the elderly, the QOL framework can act as a facilitator to keep promoting change in the different life domains. It also forces service providers to use the perspective, goals and desires of their clients as the starting point for developing personalised supports plan.

3.2. New professionals

3.2.1. A changing society…. with a higher number of elderly people

For the first time in history, a significant number of adults with an intellectual disability are living longer. The average life expectancy of a person with an intellectual disability has increased from about 20 years in 1930 to approximately the age of non-disabled citizens nowadays. According to McGhee (2011): "while the attainment of late life represents a significant achievement for people with intellectual disability, increased life expectancy has resulted in growing concerns about the extent to which disability service providers are ready to meet the changing needs of increasing numbers of older people".

Concerns also exist regarding services' ability to support older people with an intellectual disability to 'age in place'. In numbers, older people with intellectual disabilities make up a significant group of citizens with their needs often overlooked, their voices not heard and their health, well-being, quality of life and possibilities to be active citizens largely circumscribed. Despite this, they are largely invisible in European strategies like Europe 2020 and Horizon 2020. From an EU point of view, this is neither morally, socially nor economically acceptable. EU is to ensure that all its citizens exercise their rights, the right to social and political participation and dignity. This is also a group that is often cared for by informal care-givers or professional careers. These are usually women with a low level of education, low status and low wages – facts that mirror structural gender inequality and impacts on these people's health and quality of life.

As a consequence, the health and care of the rapidly growing older EU-population poses a number of specific challenges. One of these is the burden posed by mental and neurological conditions on older citizens which impacts on their working capacity, well-being, quality of life and that of their care givers, and interacts with the course and treatment of comorbidities associated with old age. One challenge in re-designing health and social welfare systems is to develop integrated care models that are more closely attuned to the needs of patients and older persons, their relatives, caregivers and health and social welfare organizations. Such care models should be multidisciplinary, well-coordinated, anchored in community and home care settings, and proactive and patient-centred rather than reactive and care and social provider-centred.

Furthermore, public health, biomedical, social and behavioural research has provided evidence for new approaches to prevention, primary care and treatment. The integration of such approaches into health and social welfare services requires cooperation across sectors and between stakeholders, and challenges the current boundaries and established norms of operation. To achieve such cooperation has been proven difficult.

Older people with intellectual disabilities have the same rights, needs and competences as other older people and specific care and social service needs. Still, in the development of more end-user-oriented care and social services older people with intellectual disabilities are overlooked or excluded. Often these people and their informal care givers are not involved in decision-making, nor are their capacity and willingness to express care preferences and needs considered or their ability to administer self-care and adhere to care plans appreciated.

Actually, the ageing in place principle is a leading inclusive principle. According to this principle, the elderly – if this is his or her choice – must be supported in the place where they wish to become old; when this is not possible anymore (due to e.g. needs that transcend the competencies and means of the service provider), transfer of the disabled people to the regular service for the elderly, including a qualitative support, must be possible.

3.2.2. A changing society… an inclusive society

Article 1 of the United Nations Convention on the Rights of Persons with Disabilities states: 'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. Services and social workers should therefore be an existential guarantee for people with disabilities and not just in care of environment, cognitive skills, or motor or professional skills. This means that at the centre of the inclusion process there are no pieces of individual but the individual itself, thought to be the original bearer of an existence capable of fulfilling itself.

At the operational level, this perspective leads to the fact that socio-educational accompaniment to the realization of a life project fulfils the wishes of autonomy, according to an operating mode that takes into account the ability of everyone and everyone to choose. It is clear that this challenge opens up the capabilities of all subjects, including that of social workers, allowing seeing completely renewed and different work horizons for social workers and the functions they should perform.

a. Emancipatory function (direct actions towards people with disabilities and their families)
* Support self-determination processes (active participation in choices and decision making concerning their lives. It is not just about paying attention to the person's tastes and preferences, but above all enabling the individual to explore the dynamic desire-reality and to increase their awareness and positioning capacities within reality.
* The recognition and support of the different phases of the life cycle of a person with disabilities, with particular attention to the adult and elderly dimension;

b. Return function - relationship between people with disabilities and their context
* The promotion of recognition of the social role of people with disabilities, that is the ability to express an active position and participate in the context they live in, taking responsibility (small or large, durable or temporary) in relation to needs and opportunities in the daily flow of social cohabitation;
* Support of the development of relationships and ties that go beyond the parent-operator couple, and which amplify diversify and make mobile, plastic, varied, the circuit of vital relationships and introduce implications dynamics and mutual change between different identities that can evolve and improve, mutually affecting

c. Transformative function – participation of services in the community´s issues
* To make the social value of disability expressed and thus contribute to the quality of life of all. For a service, a project that improves the social context means developing a mutualistic relationship that legitimizes, through concrete practices, the right of citizenship within normality, and contributes to building and extending its boundaries. Operators should be able to support people with disabilities to take an active part in building up the living conditions and to contribute to expanding the social capital of communities and territories.

In this macro-framework the social worker should assume the role of process mediator and therefore be able to:

- Promote a networking approach that promotes social inclusion processes and building bridges between services and companies, and to be able to build significant relationships with local stakeholders in order to offer inclusive opportunities to people with disabilities. They should also promote a culture of inclusion with all the resources of the territory and taking the role of the facilitator/accelerator of networking processes. They must know how to play a mediating role between the contexts of life and the characteristics of the person with disabilities (context adaptation processes, relational facilitation and so on).
- The social worker must also recognize that the relationship with the client is temporary, using the logic that people should be able to live and act in the community. People with disabilities must increase their ability to ‘stay’ in society. This means supporting the development of the ability to ‘learn to impregnate’ people with disabilities and to use any opportunity to train / develop cognitive skills and to experience ‘risks’ to people with disabilities in the perspective of increasing the potential autonomy and to experiment with authentic social roles.
- The professionals need to recognize the person as who they were before the disabilities accompanied them and to take the attitude of accompanying to the person, not the person´s substitute and to do that they need to focus on the persons goals with respect to the family´s goals or organizational/context needs. This requires involving the family and motivating families to change perspective from protective to inclusive. There is a need to accompany the person in emancipation from the family towards building his or hers own life project and dreams.

3.2.3. New challenges for professional staff

Based on the new social challenges and the impact on the staff of service providers, it is our belief that staff is missing the right skills and attitude to guarantee the Quality of Life of ageing people with disabilities. There is a need to re-skill and up-skill (new competencies, other mind set). In addition, special challenges are related to the motivation of the staff to work for/work with another target group than the group they initially have chosen to work with and to do new, more complex tasks related to physical, emotional, social and mental needs of the target group.

According to the partnership, besides the medical and support perspective, staff needs to have knowledge about communication; adaptation to all different situations and cognitive challenges; adaptation to the individual needs and conditions; and also the knowledge of putting it into practice. It is needed to preserve and expand functions when it comes to both physical and psychological wellbeing. Knowledge of a function preserving- and a rehabilitation way of working. Professional staff needs to have knowledge of social care in an environment with physical, psychological and social stimulation, social well-being, intellectual stimulation and an aim for a higher Quality of life. Fyffe et al. (2006) reported that attitudes and skills of staff played a central role in enabling services to continue supporting people to age in place (McGhee & Dorsett, 2011).

Training is generally accepted as an effective mechanism for improving employee performance and delivering organizational outcomes. Other approaches seemed to be effective also. Cooperation among different groups of professionals from different fields is recommended, to see ‘the bigger picture’ of a more holistic and tailored approach. Collaboration with schools is also needed. An example, collaboration with VET training, in order to formulate recommendations on content and method. And to plan for how to give the best training for the work that is needed to be done, yet also how to train to keep good staff. The TRIADE project is based on the need for developing more inclusive and citizen centred care, inter professional and community-based care.

3.2.4. New competences

To guarantee the best support of ageing people with (intellectual) disabilities, it is proposed that professional caregivers acquire the following competences:

a. Regarding the intervention process

- To broaden in an appropriate manner, the current evaluation protocol including tools that permit to collect data from people with intellectual disabilities and how ageing is impacting on them, on theirs needs, and on their quality life. Informal and formal caregivers who are close to these persons will be extremely relevant in this process, as well as the analysis if the environments are turned out on hostile areas or, on the contrary, they keep being facilitators (in case they were).
- To make an exhaustive analysis about the collected information, recognizing the day by day problems in ageing people with intellectual disabilities and understanding why these problems are being generated. To determine which ones are related to intellectual disability, to the ageing process, to their environments, to other individuals' characteristics, or to the concurrence of several factors that requires a holistic approach.
- To design more agile and adaptable evaluation protocols that allow a continuous adaptation to the intervention in new arising needs of people with intellectual disabilities as a result of the evolution of their ageing process.
- To develop individual support plans that clearly reflect the specific objectives pursued including the health promotion, the wellbeing and the quality of life as ultimate aims of the attention.
- To develop adapted and effective strategies that foster the genuine participation of the ageing people with intellectual disabilities in the decisions that directly or indirectly involve their individual support plan. If it is necessary, take into account in this process the nearest and most relevant persons for them in quality of process advisers.
- To implement programs which foster an active ageing process, with the purpose of delaying as far as possible the decline, of the people with intellectual disability. These programs must always be significant and motivators for these people as well as these must be adapted to their interests. In addition, they should never affect their dignity or be a source of alienation.
- To design tailored supporting plans for people with intellectual disabilities and their families that facilitate their adaptation to the ageing process taking into account that this situation is going to need more and more assistance.
- To promote the adaptation of the physic environments, materials, activities and so on, facilitating the functioning of ageing people with intellectual disabilities.
- To be able to tackle the challenges related to the understanding of the new defiant behaviours that will appear in this stage. To generate the skills that permit, through a functional behavioural analysis, to answer them.

b. Regarding the relationship

- To establish an excellent therapeutic rapport with ageing people with intellectual disability based on fundamental values such as empathy, the respect and recognition to the right to a dignified treatment, as well as a decent life quality adapted to their needs.
- To develop communication skills to address ageing people with intellectual disability using empowering communication techniques. Also to design communicative spaces where people with intellectual disabilities, can communicate their needs, preferences and decisions.

c. Regarding the organizations, coordination and work team

- To develop communication channels and an effective organization and collaboration with other professional profiles to reach the excellence in the care of ageing people with intellectual disability.
- To promote initiatives which consolidate a solid supporting network (informal caregivers, other resources, etc.). These initiatives will foster not only the care, but also the personal project of people with intellectual disabilities.
- To plan, organize and coordinate the attention and services given by formal and informal caregivers through different entities to facilitate the best supports and personal plan to ageing people with intellectual disabilities.
- To contribute to a better organization of the existing community services, allowing ageing people with intellectual disability and their families to enjoy a fully participation. To embrace an active attitude in their development, adaptation and implementation of long-term political actions related to the attention of this target group.

d. Regarding the attitudes

- To demonstrate a high degree of commitment with the good practices aimed at promoting the life quality of ageing people with intellectual disabilities and their families.
- To show constant improvement willingness, self-criticism, and analysis of developed processes in order to improve the quality of care given at any time.
- To demonstrate commitment with the personal project, wellbeing, health and quality of life of ageing people with intellectual disability.
- To avoid adopting an ‘ageism’ attitude in the attention to ageing people with intellectual disabilities.
- To always consider the planning focused on the person as central core of the personal plans to ageing people with intellectual disabilities.
- To always take care of your own training, your own professional motivation and wellbeing.

3.3. Ageism – (Re)Valorization of working with elderly and ageing people with a disability

3.3.1. Introduction

The project TRIADE was initiated within a specific demographic context in the world and more specifically in Europe, based on ageing of the population. According to the World Health Organization, the number of people aged 60+ will rise from 900 million to 2 billion between 2015 and 2050 (moving from 12% to 22% of the total global population). This is also true for people with disabilities and more specifically for people with intellectual disabilities, who are living longer due to better health care and qualitative support. It is relatively new to see that people with disabilities live longer than their parents do: this raises a new societal challenge with an urge for adaptation and efficiency of formal care. ‘Increased life expectancy presumes increased numbers of ageing people with intellectual disability. Historically, the majority of these people have aged and died in the family home, largely cared for by elderly parents and therefore remained hidden from formal care services’(Bigby 1995). ‘With increasing life expectancy though, people with intellectual disability are beginning to outlive their parents, resulting in increased need for community living services to provide ongoing care’ (Braddock et al. 2001). Within this context, society is facing new challenges in order to ensure quality of life and quality of support of this group. According to the partnership, this challenge creates a need to develop models of close collaboration between sectors of elderly and disability - giving more specific and adapted care and support within the context of community based support.

Also, there is a strong need to improve the way the elderly and the people with disabilities, particularly people with intellectual disabilities, are perceived – the image of ageing in general has devaluated during the latest decades. This is a most important barrier to develop a supported public policy and to get the work with elderly more efficient and more attractive. During the exchanges of practices, it has been observed that the negative image of elderly (with a disability) influenced both quality of life of the elderly and the quality of support delivered by the professionals.

3.3.2. Social representation of ageing : definition of ageism and stereotypes to overcome

According to R. Butler, ageism is considered as ‘the systematic stereotyping and discrimination against people, simply because of their age. The image of old age and older people is derived from an array of prevailing political, economic and social attitudes as well as from historical developments.’ Puijalon & Trincaz state that age discrimination is as present as racial and/or gender discrimination. WHO states “This analysis confirms that ageism is extremely common. Yet most people are completely unaware of the subconscious stereotypes they hold about older people. The phenomenon is a new social reality. The image of the elderly and the formal and informal discourse remain negative: the elderly are numerous, they are expensive for society and their values are old-fashioned...’

Marcia Ory (university of Texas) give an overview of six common myths, illustrating the perception many people have on ageing people, and what should be the content of the strategies to change these perception:

- *To be old is to be sick*. The reality however is: although chronic illnesses and disabilities do increase with age, the majority of older people are able to perform functions necessary for daily living and to manage independently until very advanced ages.’
- *You can’t teach an old dog new tricks.* Reality: older people are capable of learning new things, and continue to do so over the life course. This relates to cognitive vitality as well as the adoption of new behaviours.
- *The horse is out of the barn.* Reality: Txhe benefits of adopting recommended lifestyle behaviours continue into the later years. It is never too late to gain benefits from highly recommended behaviours, such as increasing physical activity.
- *The secret to successful ageing is to choose your parents wisely.* Reality: genetic factors play a relatively small role in determining longevity and quality of life. Social and behavioural factors play a larger role in one’s overall health status and functioning.
- *The lights may be on, but the voltage is low.* Reality: while interest and engagement in sexual activities do decline with age, the majority of older people with partners and without major health problems are sexually active, although the nature and frequency of their activities may change over time.
- *Older people deserve to rest.* Reality: The majority of older adults who do not work for pay are engaged in productive roles within their families or the community at large.

These beliefs are the basis for prejudicial attitudes, discriminatory practices and policies that perpetuate ageist beliefs. It can significantly undermine the quality of health and social care that elderly or disabled elderly benefit.

3.3.3. What is the risks of Ageism in working with ageing people with a disability?

It's clear that professional's attitudes towards elderly influence the Quality of Life of elderly in general and of people with disabilities getting older. Many authors conclude that ageism undermines the quality of health and social care. As Sevilay Senol Celik demonstrates 'today's students are tomorrow's health care professionals, the development and cultivation of positive attitudes towards ageing and older people is crucial.' 'If an undergraduate nurse has a poor attitude toward older adults, this can seriously impact on the care provided and the ability to staff and aged care workforce' (Flood and Clark, 2009).

In addition, the quality of life of elderly and ageing with a disability depends on their self-perception of ageing, based on the same stereotypes associated with the physiologic state, functioning and longevity. The negative attitudes towards elderly and ageing people with disabilities have significant consequences for their physical and mental health. Elderly people who experience age discrimination perceive their lives to be less valuable, and have a higher risk of depression and social isolation. ' One of the factors known to be associated with Quality of Life is one's attitudes toward ageing or self-perceptions of ageing.' (Y.Yamada) He believes that elderly who 'hold a positive view on ageing have good psychological resources even in old age. In fact, a growing body of empirical data has demonstrated that beliefs about ageing are associated with health behaviours and outcomes.'

Negative attitudes are very often a result of a lack of knowledge about elderly people: 'lack of close interactions with older people, or a fear of becoming old translating into a desire to distance one's self from 'being old.' (M. Ory)

3.3.4. How to overcome the ageism and stereotypes?

In May 2016, the World Health Assembly adopted a 'Multisectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health' covering a 14-year period of sustainable actions towards elderly and a global campaign against ageism. Considering the phenomenon of ageism and its consequences, it is necessary to set up the action in order to overcome it on a European, national and local level. Ageism is a serious issue that should be treated the same as other types of discrimination. 'Like sexism and racism, changing social norms is possible. It is time to stop defining people by their age. It will result in more prosperous, equitable and healthier societies.' (J. Beard, WHO Director of Ageing and Life Course)

A suggestion for this is on a political level, public policies need to intensify their actions toward elderly by promoting the healthy ageing, by recognizing ageing efforts and by creating a strong coordination by the different actors of elderly and disability care. 'Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programmes.'(WHO, Disability and health, Reviewed November 2016)

One of the solutions could be to raise public awareness about the issue ageism. According to M. Ory, combating ageing stereotypes is possible by raising awareness in all segments of society, as well as through educational and media campaigns.

From a practical point of view, education could play a very important role in combatting ageism. According to Prudent & Tan "educational programs at all levels, starting with elementary school, should promote intergenerational contacts. For example, at the elementary and high school levels, content on all life stages, including older adulthood, should be infused into curricula. In addition, intergenerational contact could be expanded through linking elementary and high school students to older adults. Activities such as visits to residences with older adults and volunteering to share skills, resources and record life histories would provide opportunities for interaction that could shape positive attitudes toward the older adult. Older adults also could be brought into the school system."

More contact and interaction with older people can help to overcome ageism. It may be a solution for dispelling negative stereotypes. When you feel closer to elderly, a bond may be created which results in more positive attitudes towards them.

Staying at work, volunteering or joining a community group helps people to stay physically and mentally active for longer. The principal medical adviser of the UK's government S. Davies recognizes this and states "the health benefits of this cannot be overestimated."

3.4. Informal care

3.4.1. Introduction – definition and relevance

Informal care means various types of care that are not provided on a professional basis; it enhances family care as well as voluntary care.

Family caregiving is defined by the Dutch Ministry of Health as 'the long-term care for a person in need of help that is provided by people from that person's immediate environment and which is not provided within the framework of a caring profession, in which the care provision directly arises from the relevant social relationship' (VWS, 2001). Family carers across the EU provide over 80% of all care. Approximatively two thirds of family care is provided by women, either daughters (in law) or partners of the person requiring care. Interestingly enough, family care givers usually do not see themselves as caregivers. This is true, for example, for parents of children with disabilities, partners who care for each other more than the 'average' couple do and people from other ethnic or cultural backgrounds. They rather see the care that they are giving as 'usual care', even though it can be very intensive, especially when the person with a disability lives at home. That is why statistic information available on informal carers is still relatively scarce. The main reasons why family carers provide care are emotional bonds, a sense of duty and a personal sense of obligation. Just a small percentage of family carers provide care because they have no other alternative (Eurofamcare, 2006)

Voluntary care is care provided on a non-mandatory and unpaid basis to people in need of help outside one's own social network, whether or not as a supplement to professional care or in order to support or replace carers (EIZ website, 2005).

3.4.2. What is the importance of informal care for working with ageing people with a disability?

Support services for informal caregivers vary considerably throughout Europe (Monika Riedel and Martin Kraus). In many European countries such services have not received much attention until recently. In recent years however, this notion has changed and the need for public support of informal caregivers has been placed on the social policy agenda in several countries. The underlying reasons for this are simple but pressing: on the one hand, the transition towards community based

support has an impact on the way society is organizing all care systems; on the other hand the ageing/'greying' population, the rising care costs and the anticipated labour shortages are necessitating cost control measures and other interventions in the care system.
The contribution of volunteers (e.g. students, retired people, unemployed) in the health and social care sector is a relatively new concept in most countries. Supporting elderly people, vulnerable locals and people with a small social network through the help of a volunteer is considered to be an interesting approach, that should be stimulated and supported by government.

Family caregivers are part of the social network of the client. Due to this social relationship, informal caregivers are willing to give care and (emotional) support to the client. When the ageing client still lives at home, the informal care and support can be intensive. For clients who live in institutions or sheltered homes, informal caregivers also are an important, constant factor in their lives. They often have a long-lasting and intensive emotional bond. In this way the informal caregiver contributes to the quality of life of the client. In the ageing process, meaningful relations are maybe even more important than the absence of health problems. For professional caregivers, informal caregivers therefore play a very important role. Especially, for clients with cognitive problems, informal caregivers are often 'the voice' and can give a source of information for healthcare professionals (needs, aspirations, wishes, habits, preferences, background,…) and the focus of the professionals should be to support and encourage these social relationships.

As for voluntary care, volunteers can contribute to quality of life of the ageing clients. A good relationship (and match) between volunteers and ageing clients is a good basis for carrying out social activities that can't be done by professionals – lacking the time. As the volunteer can be a good 'equal' buddy or friend for clients with a small social network, it gives opportunities for activities and participation into society and therefore, for a more inclusive society.

Many practices shared during the TRIADE meetings focused on informal care, with specific focus on the cooperation between professionals and family caregivers, as well as different strategies to support family caregivers. Family caregivers and the professionals who support them, should be aware that taking care of a relative can be (very)intensive and that it must be encouraged to create opportunities for the elderly to live independently in their own houses as long as they can and want, and to rely on their own network when necessary.
Five elements – giving an idea of the needs of a family caregiver - seemed to be essential in supporting the informal caregiver: information and advice, education, emotional support, respite care, sharing experiences.

Especially when people live at home, professional caregivers need to cooperate with the family caregivers. The Dutch 'Sofa-model' is a model that represents cooperation between the client, the family caregiver and the professional. It takes into account that a family caregiver has different roles and, in the communication and intervention, the professional should be aware of these different roles. The family caregiver can be a partner of the professional in providing the best care for the client, an informant (however sometimes a personal or emotional involved informant) and a client (when they are in need of personal care and attention themselves).

3.4.3. Informal care and its relation to the TRIADE themes

a. relation to the theme Quality of Life

Quality of life is significantly determined by having meaningful relationships. Family caregivers are part of the social network of the client. Due to this social relationship, informal caregivers are willing to give care and (emotional) support to the client. When the ageing client still lives at home, the informal care and support can be intensive. For clients who live in institutions or sheltered homes, informal caregivers also are an important, constant factor in their lives. They often have a long-lasting and intensive emotional bond. This is the way the informal caregiver contributes to the perceived quality of life of the client. For professional caregivers, informal caregivers play an important role. Informal caregivers especially play an important role for clients with cognitive problems, as they are often 'the voice' and a source of information for healthcare professionals (needs, aspirations, wishes, habits, preferences, background,…). When considering this knowledge, we see again that this will promote QOL of the ageing client.

A good relationship (and match) between volunteers and ageing clients, is a good basis for carrying out social activities that can't be done by professionals – lacking the time. Although the volunteer can be a good 'equal' companion or friend for clients with a small social network, it gives opportunities for inclusive activities and participation into society.

b. relation to the theme of the new professional and the relationship between formal and informal care

Family caregivers play an important role in the life of the client, especially when people live at home professional caregivers need to cooperate with the family caregivers. The workload, perhaps even the quality of life of the informal caregiver, should be given attention. If the informal caregiver can contribute satisfactorily to the care of the client (in effective coordination with the professional caregivers), they will contribute significantly to the quality of life of the client. If an informal caregiver is overloaded, there will be a negative effect on the quality of life of the client. Therefore, it is also the role of the professional to pay attention to the workload and the quality of life of the caregiver and, if necessary, to provide support, or to take over care (for a while!). Training and education of professionals to support informal caregivers and to signal overload, should be part of the VET policy of professional organizations.

4. TRIADE IDEAS AND REFLECTIONS: our suggestions for future actions towards an inclusive approach

For the European Pillar of Social Rights, which was adopted in April, the big challenge starts about how to support its grass root implementation. It is our responsibility to work on supporting how this could effectively contribute to people's well-being and how this could create new rights in the face of today's challenges. Among the 20 principles and rights which make up the European Pillar of Social Rights are social protection and inclusion and a debate about what kind of EU we all want by 2025.
The TRIADE consortium offers its contribution with reflections, ideas suggestions and recommendations for a transition to an inclusive society with equal rights for everyone taking into account the demographic change and the ageing of people with intellectual disabilities. Its mission will be to work on new professions skills and competences for a better quality of life.

By sharing successful (and not always easy to realize) practices, the partners could define topics to take into account when someone wants to implement an inclusive policy. These topics and the related barriers may have a different significance, scope or relevance depending on the country where the practices were developed and implemented, as they may be influenced by social and cultural realities. However, the core concept is a universal one, one that is not only determined by objective, but also by subjective, personal factors: Quality of Life. As it is in the heart of the ‘universal’ rights and according to us, therefore not to be discussed anymore, QOL is the ‘focus’ of all efforts done by the person himself, his natural social environment, professionals and society, regardless the nature of this effort (care, support, cure, creating conditions, finance,…).

Starting from the shared good practices (reflecting local or national policies) and along the four TRIADE themes (giving a framework for some critical factors of success for inclusive practices *as experienced by the partner organizations*), the members generated ideas, goals, approaches, dreams,… to deal with those factors that hinder (or make possible) a full implementation of an inclusive support of ageing people with disabilities. These ideas – without a scientific check – must be the basis for further reflection and understanding, and – that’s what we hope – should be put on the agenda of organisations, policymakers, curriculum developers and VET organizations.

It may be important for the reader to understand that the TRIADE project has to be seen within the context of the transition towards an inclusive society and a community based support system for all citizens, and in the context of the transition from a medical oriented approach towards a social approach. This is a transition that is – for sure - related to the mind set and values of all stakeholders involved. For the partner organizations, there was no discussion: inclusion is the only option. Although… it was not easy to understand each other, especially due to different interpretations of ‘inclusion’ or to different socio-historical context and starting points. We didn’t always agree on the practice being inclusive or not, but we agreed on the transition towards the social model. Starting points, local/national conditions are different... In this context we learned that it may be better to use the concept of Quality of Life rather than the concept of inclusion, which is related to the QOL-concept. QOL is focusing on the individual (with his or her preferences), while inclusion is a characteristic of society, that is or isn’t inclusive, with mainstream services accessible or not for all.

Stating that inclusion is the only option, doesn’t mean that we are not aware of necessary conditions to be realized to implement an inclusive approach. Also, the reflections below, may contribute to an active policy to create the conditions.

4.1. QOL & equal understanding

To start with: many partners were surprised that 'universal' concepts like *inclusion* or *quality of life* were not understood equally, resulting in a Babylonian confusion. As QOL is the 'core' concept, the concept needs to be introduced, shared and **equally understood** among all stakeholders (formal and informal caregivers, policy makers etc.) Actually, this is definitively not the case. We suggest to promote the Schalock–model to be used. The Schalock model is universal and multi-dimensional : Quality of Life is often challenged by physical impairments and/or mental diseases and invites for '(para-)medical' interventions. Quality of Life however, is not only determined by physical, emotional or material wellbeing: also independence (b.o. self determination) and social inclusion (b.o. personal relationships) are critical factors.

Appealing for 'equally understanding' is an invitation for organizations, policymakers, stakeholders in the educational field,… to use this concept consequently in all relevant communications, and to make it part of all (relevant) educational curricula.

4.2. QOL & the starting point

The QOL-model needs to be the **starting point** for European, national, local and organizational policies, as

-the model conceptually includes the principles of inclusion, ageing in place, social rights, full and active citizenship (see the Universal Declaration of Rights), and

- the model is supported by scientific research in the field of Social Sciences and Disability Studies.

This suggestion is closely related, if not equal, to the suggestion to define guidelines and measures to make public/mainstream services, such as health care, education, life and job coaching, housing, transportation and culture, inclusive and accessible to all citizens, regardless age, impairment or whatever condition.

It is considered important to include the rights of people with disabilities between the different policy levels. The partnership underlines the fact that all people have **the same rights** (including the right to qualitative care and the right to realize their full potential), irrespective of age or disability. In this respect, we stress upon the importance of qualitative care for all, in which the quality of life of the people involved is used as a key framework of reference.

Governments should make clear what 'at minimum' needs to be realized regarding QOL, as a criterion for subvention/support of accredited services. Accreditation needs to be linked to evidences of inclusive practices and/or an explicit policy. When defining, monitoring and evaluating the quality of services, one needs to focus on how they affect the quality of life of people using them. Government should set a **common framework**, linked to the human rights and QOL of the users, rather than standards only focusing on technical or staff related issues. These standards must be part of a (national) system for inspection of the quality of services.

The existing legal frameworks should be **revised** and amended to ensure that all hindrances to the successful implementation of reforms are removed.

On the organizational level, the transition towards a consequent implementation of the QOL-model is a process that influences and has an impact on all domains of management. All organizations and staff need to work – continuously monitoring and evaluating - towards goals that are focusing on QOL and inclusion. At the same time, it is necessary to promote transformational leadership, with different leaders that stimulate participatory processes of interest groups, that define objectives on where the entity should work towards, and that support professional teams to develop personal support plans, organizational strategies and improvement of service and optimization of human resources (4.5) and new technology (4.11), based on the needs, rights and views (4.4) of the clients and the persons who are important for them (4.6).

4.3. QOL & assessment/evaluation

The question of how to **evaluate** the contribution of services to the Quality of Life of elderly people with disabilities evoked a lot of discussion. Some partners refer to the development of **assessment** tools that can measure the quality of life of the ageing persons. Others express their concern that these tools may risk to reduce the complex and dynamic issue of quality (of life) to a more static and technical one, to something that can be scored according to fixed categories that are defined beforehand. Therefore, this approach suggests to give more attention to continuous processes of dialogue, negotiation and reflection through which a myriad of meanings and problem definitions can be taken into account. At the same time, however, it is mentioned that the construction of an instrument with certain indicators (not necessarily scores) may be vital as a starting point to reflect – together with the stakeholders involved – on what happens/should happen in real practice. In this respect, some partners argue that without certain tools for reflection, the required process of questioning, deconstructing and reconstructing interventions may never occur. A Personal Outcomes Scale, based on the Schalock-model and adjusted to the ageing people (with a disability) may be very useful, as the perception of the individual quality of life is central. Nonetheless, we should remain cautious about how and to which end these instruments are used in practice.

4.4. QOL & client's focus

Professionals have to listen/need to listen to the client. Key idea in this reflection is not to have the client in focus, but to respect and take into account **the client's focus**. Professionals need to have the client's view in focus. They need to work with the client, and the client participates in decisions regarding his or her life. Professionals should therefore work together with the client, family or anyone else that the client chooses.

Staff should **only** support clients at the time that needs need to be supported. All things that clients can do on their own don't need support (they should do, this emphasis and increases **autonomy** for the client. People with disabilities should be seen as a **contributors** to society. They are a resource to others. The staff must also have a 'risk approach' that allows the client to try, to take risks and to sometimes fail. Not be overprotective so that they hinder client's development and growth.

The partnership argues that elderly people should remain able to exercise control over decisions and actions that have an impact on their lives. In this context, the ageing-in-place-principle has been defended: every person (with disabilities) should have the right and the possibilities to choose where they want to live. However, in different contexts, the question remains whether and how the contemporary discourse on 'free **choice'** is also realized in practice.

4.5. QOL & HRM/Q management

Implementation of inclusive policies and practices will be successful only when organizational HRM policy and Q management are aligned to the QOL-model. Organizations have to develop a Quality management system that is coherent with the QOL concept (process and outcome indicators need to

be selected according to the QOL model; the organizational/environmental conditions/prerequisites for QOL are subject of evaluation).
Also, an organization must align its Human Resource Management policy to the QOL model: tools need to be developed to be used during the selection process of new staff, tools for evaluation of staff, a consequent VET policy (especially addressing the actual staff that needs to be trained to deal in the best way with new clients with new and other support needs, but also to change attitudes and mind sets). A systematic and coordinated training curriculum is precondition for the establishment of services in the community and in ensuring personnel will be adequately trained. Training curricula need to take into consideration initial education, in service training and lifelong learning.

4.6. QOL & the curriculum, training and VET-policies

Training curricula need to take into consideration initial education, in-service training and life-long learning.

Inter- and multi-disciplinarity, a holistic approach, ‘inclusive’ skills, perceptions and beliefs must be taught (e.g. at school). Curricula – at high school or at whatever level or context of education and training - need to be evaluated to see how they meet the necessary mind set, competences and attitudes to address QOL, the support needs related to ageing and those related to disability.
TRIADE partners point out that qualitative education and training is not only promoted by sharing and discussing theoretical knowledge, but also by making explicit links to practice. To this end, they (e.g.) advocate to employ teachers with experiences in the field. For the partnership it is clear that education and training (also at the level of the organization as part of the HRM/VET policy) has to fill the gap between ‘old’ competences/visions (related to the mere medical approach) and ‘new’ competences/visions (cfr. holistic approach, focus on quality of life). Since not all organizations have the same means to provide training, it is suggested to look for additional funds and initiatives, that are necessary for supporting the continuous development of care practitioners. In this context, specific attention should be given to the cooperation and mutual exchange of knowledge and competences at different levels (government, organizations,…). Whenever cross sectoral partnerships are established, it is suggested to organize trainings with a mixed audience from the fields or organizations involved.
Overall, it is key to make explicit and define the profile of the ‘new professional’ to define the training goals, for initial education and for continuous training.

As shared practices showed, education can positively influence (nursing) students’ attitudes towards elderly, which is a starting point for (more and skilled) new professionals in the fields. Combatting ageism has to be a global action on international and national levels, but – as seen in other fields - education plays an important role: the new/young professionals have the right basic attitudes.

Specific attention must be given to the vocational training of the actual staff as this may be the main challenge for short term successes: new skills, new attitudes are often not in line with the motivation to work in the field of the elderly. A caring (charitable) attitude, as part of a global belief system that is not working towards empowerment is a serious blocking factor, just as the argument not to have chosen to work with (e.g.) Down syndrome ageing people.

4.7. QOL & clients social network

Partners realized that if we want to be serious about inclusion in society, clients should not just live in society, but should be included in the social community and participate actively; they do not just meet staff. Organizations and services are far too much organizing activities for their own clients within their own (infrastructural) context.

Professionals need to be invited to reflect on their relationship with clients and the efforts that are done regarding this relationship: according to the partnership this reflection must result in a transition from efforts done to work on a good relationships with the client (as a goal) towards a good relationship "professional – client" as a mean, not a goal and as part of the strategy. Professionals don't need to invest only in their relationship with the client, but they need to invest especially in the relationship of the client with his social network and society. The opportunity to work with volunteers (4.10.) to support clients to participate in activities in the local community and to build a social network should be taken into consideration.

4.8. QOL & collaboration : inter- and multi-disciplinarity

Collaboration beyond fields & integrated educational curricula (covering the transversal skills and competences that are related to collaboration and that go beyond the domain specific field) are key factors for a successful inclusive approach and policy.

Organizations must become aware that a 'sectoral' approach is not promoting an inclusive approach and doesn't guarantee QOL of clients. Organizations need to be encouraged to work together, in an cross sectoral way or within the context of a network of services, at least to benefit from the competences available in other sectors to support the ageing clients in the best way.

The main goals of a cross-sectoral collaboration are linked to both the client (enhancing Quality of Life of the ageing people, creating conditions for the best support and care) and the professional staff (development of competences - skills, attitudes, mind set,… - in all sorts of organizations involved). The ageing in place principle is the leading working principle, the openness to share competences is what makes this possible. In the end, ageing people with a learning disability can live as long as they want in the place of their choice – with reasonable adjustments and always guaranteeing the personal integrity - , but once ageing in place has reached its limit (due to e.g. dementia, safety or high level of needs of support) they can move to a facility for the elderly that is competent to support in a qualitative way the ageing person. But also then, ageing in place is at stake, referring to a continuity of what determines 'being and feeling at home' (not moving to the other side of the country, but to a 'local' facility in the neighbourhood of friends and relatives; with a room or flat, decorated according to your preferences;…). And also, moving to another place, is not a bad thing to be avoided at all times, but is part of a continuous, integrated care system.

Within some partner countries collaborative practices are present. Establishing the desired collaborations is not evident for many different reasons: a conservative or self-protective attitude within organisations, limited knowledge of strengths and competences of the other/adjoining fields, negative perceptions of the elderly field and the elderly, a medical approach, low educated staff, institutionalisation…

Community based options also are hindered by unfamiliarity: for clients of services for the elderly, it is often difficult to accept a person with an intellectual disability (e.g. a Down syndrome person) as a

co-habitant. This is reinforced by the attitude and skills of the staff, who do not know how to deal with disability related support needs of the person with an intellectual disability.
Actually, working in an inter-sectoral way is not made easy, as it is challenged by (national) regulations that are different and often contradictory in the different fields. Efforts to work toward inclusion and QOL are not reinforced. The need for integrated regulations and financing systems – instead of the contemporary split in regulation between disability and elderly sectors – has been named several times.

Partners involved have some factors of success of a collaboration between services from different fields in mind:

- a formal agreement between the organisations, ensuring structural evaluations of the work in progress
- clear and systematically evaluated goals on all domains of management,
- ample discussion/reflection on the underlying (shared?) beliefs and (common?) vision, always respecting the identity, strengths and competences of the individual organizations - the complementarity of competences is what makes the difference,
- a consequent VET strategy, with several methodologies : outreach, formal training and supervision while ’exchanging’ the competences beyond the borders of the sector,
- the active involvement of the client and his network.

If different fields work together, different specialties and educational backgrounds will meet and will need to work together. Multi-professional teams may be very important for the holistic approach and the realisation of QOL as it is promoted by the partnership.

Besides, the economic value of collaboration must be stressed: when organizations collaborate, more can be done with the same means. And,… responsibilities are shared responsibilities.

4.9. QOL & perceptions

As ageism refers to the perception on ageing people, it is related to broader hindering factors, such as labeling, categorization etc. These perceptions influence the nature of support and the outcome, and – in this way – influence the perception and attractiveness on (professional) care and support of the ageing people. An additional disability within the elderly reinforces this perception.
The partnership emphasizes the necessity to interrupt current processes of categorization, and suggests future polices not to base on externally defined categories and associated care strategies, but rather on needs and support needs.
In order to fight existing stereotypes of older people, it is mentioned that society should consider elderly more as a resource for society. Campaigns, or even legal procedures (in case the image of elderly people is damaged) have been suggested. Interventions and support should be based on talents, strengths, experiences of the ageing person to contribute – with new roles - to the social environment (to be seen as broad as possible – the residence or the community).

Undoubtedly related to older perceptions on the elderly, their roles and needs, and the consequent choices, policies and efforts, formal as well as informal care/support jobs are not highly regarded and are low paid. If these conditions – and in general the working conditions of professionals - do not change, the hindering perception will be difficult to be changed.
In this same context, it is argued that, since policy makers wish to encourage informal caregivers to be more present throughout the ageing process of family members, they should also provide the

resources (such as a leave, services, financial means) to support the balance between work and family life.

For the TRIADE partnership, the revalorisation of the elderly and of working with the elderly and the elderly with disabilities needs to be the reinforced within European, national, local and organizational policies. This could be done by, for example, promotion and recognition of active and healthy ageing citizens, raising public awareness about the issues ageism, prevention of illnesses, programs to keep ageing people at work, promotion of volunteering, creating opportunities for intergenerational contact and interaction in all kind of societal contexts,… Educational programs at all levels, starting with elementary school, also can promote intergenerational contacts, as this is also the case for any 'inclusive' preschool or educational setting. Other educational methods, curricula not based on a biomedical model, focusing on rights for all, tailored support, self-determination,… will increase students negative beliefs and attitudes towards elderly.

4.10. QOL & informal partners

Quality of life is, to a considerable degree, determined by having meaningful relationships. Family caregivers often have a long-lasting and intensive emotional bond. For clients still living at home as well as for clients who live in institutions or sheltered homes, informal caregivers are an important and constant factor in their lives, and therefore, may contribute significantly to the quality of life of the client. The quality of the professional care and support will improve if informal caregivers are in the picture, as this creates opportunities for the professional to concentrate on their role as expert or specialist and do 'disability' or impairment or handicap specific actions.

The extent to which different countries develop an active policy and approach on how to reach out to the informal caregivers of clients still living at home and to develop services to support and to relief them varies, depending on the cultural and political background. Both types of informal care - family care (or caregivers within the social network of the client) and voluntary care – need to be taken into account, but – logically – need a different approach.

Family caregiver

General policy in European countries encourages people to live independently in their own houses as long as they can. The growing ageing population, rising care costs and the anticipated labour shortages are necessitating cost control measures and other interventions in the care system. Therefore, the contribution of informal caregivers to the care system is increasing.. The partnership sees a role for public authorities to valorise the family caregiver by recognizing a caregiver statute, defining caregiver rights (e.g. to conciliate professional and family related aspirations) and giving incentives. Local support systems or services for the family caregiver need to be developed – together with the family caregivers - and amplified and made visible and accessible. These systems can provide tools or training on specific needs, related to both ageing and disability.

Professional organizations should develop a vision and policy with regard to the role and the contribution of the informal caregiver and the way in which professional care and informal care can be aligned. A systematic evaluation of the workload, the strength and the frailty of the persons involved is recommended. VET-initiatives for both professionals and informal caregivers at the same time has an added value (mutual understanding), just as development of support plans together with the family caregiver is valuable.

Volunteers

Volunteers supporting elderly people, vulnerable locals and people with a small social network offer opportunities to enlarge the quality of life of ageing, disabled people (whether or not living in an institution) and contribute to an inclusive society. What is needed to foster and facilitate this action should be considered in a systematic way.

Government and organizations benefit from a clear vision on the contribution of volunteers in the health care sector. The implementation of this policy requires a coordinated approach, with specific actions allocated to each stakeholder.

Public authorities should develop strategies to create awareness and to initiate the public debate that volunteers can make an important contribution to the quality of life of the ageing person with a disability and that this contributes to an inclusive society. To explain it within the framework of 'saving money' is a bad motive.

Social institutions should develop methods and organisational models to support and to facilitate voluntary commitment, to recruit new (younger) groups of volunteers, to formulate clear rules on how volunteers are linked to clients, and to develop training and initiatives that create chances for volunteers to share experiences with professionals.

For professionals, it is very important to learn to communicate with, trust and support volunteers starting from a shared responsibility, with – for both parties – clear contributions to this responsibility.

4.11. QOL & the profession

All lessons learned, all TRIADE themes and the reflections bring us to a professional with the 'right' vision and beliefs, sufficient knowledge and skills on medical, mental and disability related items, qualitative caring and supporting skills, 'bridging' skills, genuine collaboration and responsive social and communication skills : this is much more then what the professional was taught until now.

The professional competences expected exceed the mere support or care – although the skills related to the new needs of the client, due to ageing or mental problems ask for support or care for these needs. Working in accordance with a holistic model, working with the client from his perspective and working with the social network and other (mainstream) services is complex, needs flexibility and an attitude that is – for sure – not controlling or ruling.

The partnership stresses on the importance of evidence-based practices and strategies based on a good theoretical grounds to be part of the curriculum and VET-plans of organisations, completed with items related to methodologies that focus on the clients perspective and his/her personal goals, in accordance to the assessed support needs, in collaboration with this client and with systematic reflection and evaluation of the outcome, i.e. QOL.

It may be clear that this approach is aligned to the Life Long Learning (LLL) approach: the actual staff needs training in how to promote independence, ways to realize social participation and inclusion, how to improve self-efficacy, and how to deal with the new needs related to ageing and disability. Special attention may be given to ways that prevent from the 'eclipse' effect that can happen when signs related to the intellectual disability are not distinguished from signs that indicate an ongoing process of ageing or dementia.

Partners of the project stress on the importance of an open mind for new technologies that could enhance ageing people's quality of life. In this context, specific reference has also been made to tools and (IC) technologies that can help them to express these needs and aspirations themselves, as pure technological tools are already developed and available (not yet known in a sufficient way). To encourage the use of these technologies, they should be made accessible for all and be implemented in the education and training of practitioners.

contributions by

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- Irene Wiezer, Anthony Polychronakis – City of Rotterdam (NL)
- Maria Sorzano, Jose Campillo, Julian Iniesta, Jose Gil - IVASS, Valencia (E)
- Daniela Moro, Zita Krastina, Franca Barison – Irecoop, Padova (I)
- Evelyne Breye, Koen Aelvoet – Sint Vincentius, Kortrijk (B)
- Joke Vandaele, Joyce Vansteenkiste, Johan Warnez – vzw den achtkanter, Kortrijk (B)
- Jill Mattsson, Monika Tolla – Karlstad Kommun (S)
- Sara Morgan, Marie Skoghill – Eskilstuna Kommun (S)
- Miljana Dejanovic, Laurence Planchais – Dep. Val de Marne (F)
- Elena Curtopassi – ENSA network (EU)

SUMMARY

◦◦◦ THE STARTING POINT

- QOL as starting point for European, national, local and organizational policies
- Guidelines and measures to make mainstream services inclusive and accessible to all
- Accreditation from government linked to evidences of inclusive practices / an explicit policy
- Organizational level: systematic evaluation on QOL and inclusion based goals

◦◦◦ HRM/Q MANAGEMENT

- Quality management system must be coherent with the QOL concepts
- HRM-policy must be aligned to the QOL-model

◦◦◦ CLIENT'S FOCUS

- Not: have the client in focus, BUT: respect and take into account the client's focus
- Staff only supports clients at the time that needs need to be supported

◦◦◦ CLIENT'S SOCIAL NETWORK

- Move towards a good relationship 'professional – client' as a mean, not as a goal
- Professionals need to invest especially in the relationship of the client with his social network and society

◦◦◦ THE CURRICULUM, TRAINING & VET-POLICIES

- Inter- and multidisciplinarity, a holistic approach, 'inclusive' skills, perceptions and beliefs must be taught
- Education and training to fill the gap between 'old' and 'new' competences/visions
- Specific attention: vocational training of the actual staff
- Cross-sectoral partnerships: organize trainings with a mixed audience from the fields

◦◦◦ EQUAL UNDERSTANDING

- Equal understanding of concept QOL
- Use it in a coherent way in communications
- Use it in educational curricula

◦◦◦ THE PROFESSION

- A professional with the 'right' vision and beliefs, sufficient knowledge and skills on medical, mental and disability related items, qualitative caring and supporting skills, 'bridging' skills, genuine collaboration and responsive social and communication skills
- Importance of evidence-based practices and strategies based on a good theoretical ground to be part of the curriculum and VET-plans of organizations
- New technologies should be accessible for all and be implemented in the education and training of practitioners.

◦◦◦ PERCEPTIONS

- Interrupt current processes of categorization
- Future policies must not base on externally defined categories and associated care strategies, but on needs and support needs
- Better wage and working conditions
- Educational programs can promote intergenerational contacts
- Promotion and recognition of active and healthy ageing citizens

◦◦◦ COLLABORATION: INTER- AND MULTIDISCIPLINARY

- Collaboration beyond fields:
  - o work together in a cross-sectoral way
  - o benefit from the competences available in other sectors
  - o the ageing in place principle = the leading working principle
  - o need for integrated regulations and financing systems
- Factors of success of a collaboration between services from different fields:
  - o a formal agreement between the organizations, ensuring structural evaluations
  - o clear and systematically evaluated goals on all domains of management
  - o ample discussion/reflection on the underlying beliefs and vision
  - o a consequent VET strategy, with exchange of competences
  - o the active involvement of the client and his network
- Multi-professional teams

◦◦◦ INFORMAL PARTNERS

- Family caregivers
  - o family caregivers need to be valorized: recognizing a caregiver statute, defining caregiver rights and giving incentives
  - o local support systems or services for the family caregiver
  - o provide tools or training on specific needs
  - o professional organizations should develop a vision and policy with regard to the role and the contribution of the informal caregiver
- Volunteers
  - o clear vision on the contribution of volunteers in the healthcare sector
  - o public authorities should develop strategies to create awareness and to initiate the public debate that volunteers can make an important contribution to the quality of life of the ageing person with a disability and that this contributes to an inclusive society
  - o clear HR-strategy, systematic support of volunteers, clear rules on how volunteers are linked to clients, training and initiatives that create chances for volunteers to share experiences with professionals

◦◦◦ ASSESSMENT/EVALUATION

- A personal Outcomes Scale, based on the Schalock-model and adjusted to the ageing people with disability
- Give more attention to continuous processes of dialogue, negotiation and reflections

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Full text, see final report pp. 19-26 TRIADE

CLOSING TIME

Referring to the critical role of the mind set or the belief system of everyone who is part of the 'social' environment', it is critical to belief that 'when you believe, you will achieve'. This belief determines the efforts (to do…, what and how much…), the choices (to be made…), the steps (to be set..),…..

During the project period, efforts were done by the members of the partnership to share their aspirations and policies, successes and failures. Sharing practices and lessons learnt is widely accepted as a critical factor of success for all kind of transitions, including the one towards an 'inclusive society or the one from the medical approach towards the social inclusive approach of ageing or disability. All partners were continuously willing to share successes and failures and to expose themselves in a vulnerable position. This was the basis for a nice, 2 year experience, with full respect for all approaches, resulting in friendship and a stronger belief in inclusive policies..

The contribution of all partners are fully appreciated, with recognition of their (individual) vision and competences. Specific things come into my mind (being aware that these things are only part of a great commitment): thanks to…

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… our Swedish partners Johan Lindström, Marie and Sara, from Eskilstuna Kommun, and Lars Goran, Lena, Jill and Monica from Karlstad Kommun, for sharing local and national practices that are inspiring examples of all elements that need to be taken into account for effective implementation of inclusive models, and for broadening the project with the themes of dementia, communication and technology;

… the regional minister for Social Affairs of the Veneto Region, General chair of the ENSA network Manuela Lanzarin, Daniela Moro, Zita Krastina, Franca Barison (Irecoop) , Guido Gasparin, president of the cooperative Solidarietà for welcoming us and commenting regional policies and practices in a

context that – in each detail – is a perfect example of inclusion and of believing in the power of community networks and the potential of both, people challenged by a disability ànd professionals;

… Miljana Dejanovic and Laurence Planchais (Dép. du Val de Marne) for giving attention to the hindering 'ageism', for showing us the potential of a progressive cross sectoral and cross cultural approach, and for the continuous evaluation of the project;

… Evelyne Breye and Koen Aelvoet (Sint Vincentius) for promoting 'our' successful cross sectoral collaboration in Flandres and Europe, and for being an advocate of the transition towards a social inclusive model, away from the pure medical approach;

… Ilse Goethals, Jorrit Campens, Tineke Schiettecat and Nico Dewitte (University College Ghent), for helping us to stay focused on QOL, the high level coordination of the discussions and summary-times, for the 'scientific' input of the project and the link with the 'curriculum';

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… Petra Vercruysse, general manager of vzw den achtkanter, for believing in the value of European exchanges, and Joke Vandaele and Joyce Vansteenkiste, my young, enthusiastic close colleagues for helping to keep to project on track, and for being 'in the neighborhood' for support and critical comments during the whole project period.

Together we learned that

** the* focus *is on the* **client's focus** *and* **quality of life***,*

** the* challenge *is* **labeling and negative perceptions,** *ageism being one consequence*

** the* mission *is to work towards* **'new' professionals**

October 2017

Johan

APPENDIX: good practices presented and shared during the transnational meetings

1. Look inside to change

NAME OF HOST ORGANISATION/INSTITUTION	**IVASS INSTITUTO VALENCIANO DE ACCIÓN SOCIAL**
TITLE OF THE GOOD PRACTICE	**“LOOK INSIDE TO CHANGE” Learning what I don’t know and relearning what I know.**
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Let the participants to lead a formative experience based on resolving the needs that as therapists day after day detect when caring people with intellectual disability.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	To share an innovative methodology in a training action which is focused on the student and includes an accompaniment in a real change process.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	During 3 years a training action with a group of professionals caring people with intellectual disability has been carried out. Every year, the contents of this training action, has been set taking into account the needs expressed by IVAS and the participants themselves. The used methodology proposes a student´s companion (the professional) where, starting by theoretical concepts is coming into real situations, being the daily experiences the group learning drive. The students themselves are who develop among the classmates this model for change, establishing a space where to share, not only difficulties and worries, but also achievements and projects. To think about the people we work with, to come up with proposals to support their development, reflect on other point of views, to learn other ways to do things, To question what we did for a long time and has already become stagnated are key factors in this methodology attempting to mobilize the bases of the work that therapists do within the intellectual disability field. A pedagogy which respects the student´s knowledge, empowers him/her, its value as professionals is recognized, but at the same time it motivates them to improve, to be analysed and to question what, for a long time, held his/her energy and professional effort. 3 training years 3 25-hour courses each A balanced combination of theory, as a way to learn new ideas; and practice where learned things are implemented and we share the work done. A process that starts on the classrooms but ends in the working space of every student. A fourth final phase in which every student, already in his/her working surrounding and immersed in all the circumstances that limit him or her, evaluate himself/herself again and observe which change spaces is able to mobilize. And from the training, the support for the change.
DESCRIPTION OF TARGET GROUP	25 therapists from centers attending people with intellectual disability (residences, occupational centers, sheltered homes)
MEANS/MEHODES OR TOOLS	• Theoretical-practical sessions.

USED	• Dynamics of reflection and building shared knowledge. • Presentation of cases and results from the intervention carried out during the course. • Presentation of good practices that every student develops in his/her center. • Individual training sessions in all working centers.
SKILLS INVOLVED FOR THE CAREGIVERS	To ensure that students acquire **competences to design and implement training plans of practical skills** in people with intellectual disability. Let students acquire **knowledge and skills which facilitate the problem solving** to train the practical skills which students will cope with in their daily working practice. To ensure that students acquire the competences **to analysis the therapeutic potential of the activity**. Let students acquire strategies **to select what activities are meaningful to the people with intellectual disability who students are working** with and establish the right channels to improve their participation. To ensure students acquire skills **to evaluate the efficacy of intervention programmes** based on the activity. Let the students acquire competences to carry out **those modifications needed to improve the intervention programmes** through the activity which is currently already developed. To ensure students **share the good practices developed in their centers for the programmes in which they are responsible along other students**, adding in them the good practices developed and shared by others.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Active participation Empowerment Reflection Self-criticism Empathy Receptiveness
RESOURCES NEEDED	Training spaces Mobile tables and chairs Paper and stationery consumable items Laptop and projector PowerPoint slides with contents and sessions development.

2. Professional needs

NAME OF HOST ORGANISATION/INSTITUTION	**IVASS INSTITUTO VALENCIANO DE ACCIÓN SOCIAL**
TITLE OF THE GOOD PRACTICE	**Students job-training programme in IVAS centers on certifications and specific fields which offer added value and an improvement of quality care of disabled people who is ageing.**
GENERAL OBJECTIVE OF THE GOOD PRACTICE	**To improve the assistance and satisfaction of people with disability in an ageing situation thorough the combination of three factors:** 1. The formative demands stated by the professionals; 2. The training needs identified by supervisors and technical/director teams 3. The needs required by people with disability who are ageing. To highlight that these three elements of the triangle are key to improve the care and guide the services towards inclusive models of intervention..
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	IVAS pursues the life quality improvement of people with intellectual disability who are cared in its different services (day centers, occupational centers, residences and sheltered homes). One of the most important challenges is reorienting and, if it is necessary, to create units or services which give assistance to the new needs of people with disability who are ageing. The professionals training, their rehabilitation and the incorporation of new professional profiles are the roots of this reorientation. The incorporation of students from new certification curriculas, through training practice agreements, enhances a direct evaluation of the impact of these new skills and competences on assisted people..
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	IVAS is aware of the ageing, both if it is normative or pathologic, raises a combination of new needs of this vital cycle of people. From the point of view of biopsychosocial model, this needs have to do both with personal autonomy -committed by the biological limitations inherent of ageing process, particularly if this develops with disease- and with psychological and social circumstances resulting from surrounding and contexts (barriers or facilitating factors) in which persons tries to cope with. These needs are, sometimes, very basic or simple (Who pushes the wheelchair?, who peels the fruit? and others more complex (Who diagnosis I am depressed or I am starting a cognitive impairment or a dementia? Ones and others have in common the need to be managed in the most efficient, respectful and satisfying way for the user and the own services. The training process and the new professional profiles are understood by ones and others as an important tool to cope with these needs with success. In some IVAS centers, through agreements with both training entities, Secondary schools or universities, are developed internship periods with trainee students of several certifications offered by these training organizations (some of them are new certifications which are not officially included by IVAS in its labour list of professionals workers, such as is the case of "Formative cycle of Dependence attendance of Secondary schools) which offer new professional profiles more updated and suitable to the users needs attended in these centers.

	Specific examples of good practices in IVAS are: a) Trainee students of Miguel Hernández Psychology University have accomplished a psychopedogical evaluation in Occupational center La Tramoia in Elche which has served for, among other things, to collect information about the ageing of its users b) In the occupational center el Maestrat of Benicarlo, students of formative cycle of dependence attendance of secundary education school develop leisure time activities on Fridays evening for people with disability taking into the account the needs and likes of those who show ageing symptoms both normalized or not. The integration of trainee students in this daily dynamic of taking care of disabled people in our centers makes it easier a straight evaluation of the merits or not of a definitive incorporation of these profiles within the organization. In addition, it makes evident, in some cases, the need of changes in our workforce in order to improve their effectiveness in responding to our clients needs.
DESCRIPTION OF TARGET GROUP	Students of certifications linked to the fields of intellectual disability or ageing (psychologists, Occupational therapists, students of secondary formative cycles such as Attendance of people on dependence situation, Adapted sports technicians, gerontology...) IVAS professionals attending directly or indirectly to people with disability in an ageing or dependence situation. Human resources staff responsible of elaborating the jobs catalogue, of recruitment processes and training plans design. staff from the **customer/client** Service provision area responsible of needs detection and study from attended target people.
MEANS/MEHODES OR TOOLS USED	- Cooperation agreements with formative entities. - Trainees students internship programmes to guarantee the optimal use of them and their positive impact on the organization. - Assessment of new professional profiles aimed at community services. - Design of new functions and professional skills resulting from these new needs. - Staff recruitment. Performance evaluation. - New formative methods.
SKILLS INVOLVED FOR THE CAREGIVERS	basic skills of elderly people health attendance. Training on normative ageing. Training on pathologic ageing. Training on life quality and inclusive models.
ATTITUDES INVOLVED FOR THE CAREGIVERS	*will to care service* *Respect* *Empathy* *Flexibility* *Kindness* ***Patience***
RESOURCES NEEDED	Cooperation agreements with Formative entities which may provide from its catalogue of certification new professional profiles into our organization. Evaluation commission on internships formed by the management bodies and people responsible of the human resources and Service provision areas. Trainee students internship questionnaires linked to the impact that these professional profiles have on the people with disability and/or showing ageing symptoms. Questionnaires that collect the vision of

the different centers professional categories.

The acquired experience during the years developing this good practice confirms that not only trainee students obtain professional experience during the internship but also in some cases they have been a good example and spur for our professionals who should have been from the beginning their guides or models to follow in these periods. We highlight that, in many occasions, the mere presence of these young students with news styles and new attitudes in their daily routine in our centers has a positive impact in the target group attended.

3. Informal care

NAME OF HOST ORGANISATION/institution	**IVASS INSTITUTO VALENCIANO DE ACCIÓN SOCIAL**
TITLE OF THE GOOD PRACTICE	Training to target group families (elderly people) and the Community
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Generalize objectives and bio-psycho-social and functional center actions with families and community regarding dependent elderly person care, in order to improve its life quality and decrease the caregivers stress.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	To detect by our center and community the needs of knowledge, information and actions of informal caregivers regarding the care of dependent elderly people; specifically those who suffer from neurogenerative disorders and deep geriatric symptoms.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The day center interdisciplinary team detects the training and information needs of families and community through the following means: - Phone calls - Face-to-face interviews - Agendas - Clinical observation during the daily care - A demand from municipality social workers related to family or community needs of training or information. - Verbal communication from the elderly people social context to improve the general knowledge and information about the dependent early people issue. These needs are collected and classified. Two types of actions addressed to elderly people families are being carried out depending on whether it is considered to train or inform at individual level due to the particular case idiosyncrasy; or it is preferable to do the same by groups, because a specific need is common to several families. - Individual interview and intervention by the professional or professionals involved on it. - Community talks The topic to develop focuses on: - The neurodegenerative process and its training and information. Action plan of the center. Guidelines to be implemented at home. Management of short/long term evolution. Management of needed procedures to obtain technical helps (support products) and orthopedic materials for the final user. - Modification and adaptation of elderly people home surrounding. - Strategies to stress management - Geriatric syndromes: dysphagia, incontinence, dementia, motionlessness, falls, plurypathology, malnutrition - Fragility (age factor) - Heath enhancement: active ageing, health cares Once the need or demand is settled, the multidisciplinary team determines the topic to address and the professional who are going to take part. One training day is proposed for all these cases and the center prepares the training. Families are called thorough agendas or ordinary mails. The community is called through the municipality or other means such as local newspapers. Once the planned training has been given, a follow-up is carried out to the trained families through phone calls, agendas and as many individual

	interviews as required. Follow-up is not carried out in the case of the community. In neither case evaluation is carried out. Just some annual indicators are set up by the center understood as proposal of improving the service quality and a report of developed actions. The action impact on the families is evaluated day by day and registered in al professional follow-up sheets.
DESCRIPTION OF TARGET GROUP	Caring families, who usually are the spouses or sons/daughters who have not received either any previous instruction, nor training about degenerative ageing process or/and dementia and problems associated to it. Also groups of non professionals people previously selected by the municipality, who usually are unemployed or people in risk of social exclusion
MEANS/METHODS OR TOOLS USED	The methodologies used for the treatment of this general objective and the situation control are: - The illustrative-explanatory method (exhibition) - The reproductive method. - The deductive method (through key factors than enhance the "insight" of information conveyed. Visual, verbal and practical means are used.
SKILLS INVOLVED FOR THE CAREGIVERS	- Communication skills - Identification and solving problems - Guidelines application - Understanding of consequences and their prevention. - Theoretical knowledge - Teamwork
ATTITUDES INVOLVED FOR THE CAREGIVERS	- Patience - Situation acceptance - Optimism - Person-oriented service - Respect to people dignity and their privacy and rights - Discretion - Empathy
RESOURCES NEEDED	- Professional time - Physiotherapy, occupational therapy, nursery and psychology materials. - Laptop and projector. Transparences. - Written materials

4. Inclusive support of disabled ageing people

NAME OF HOST ORGANISATION/INSTITUTION	VZW DEN ACHTKANTER, KORTRIJK (B) SINT VINCENTIUS, KORTRIJK (B)
TITLE OF THE GOOD PRACTICE	Inclusive support of disabled ageing people
GENERAL OBJECTIVE OF THE GOOD PRACTICE	- Inclusive support of disabled ageing people, focusing on 'ageing in place'. - Promoting Quality of Life of disabled ageing people. - Cooperation between mainstream services for the elderly and services for disabled people. - Enhancing competences of staff (mind set, skills, attitudes) in both fields by outreach, training, supervision, ….
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Inclusive and deinstitutionalization related actions are challenged by significant different mind sets and attitudes and by missing skills to support ageing disabled people. By sharing knowledge, beliefs and practices and by concrete support of staff by outreach interventions (in both directions), we are reducing the gap.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The formal collaboration between vzw den achtkanter (field of disability), and Sint Vincentius (service for the elderly) has been established in 2010. This intersectoral approach aimed to give answers to 3 questions: - How does this intersectoral collaboration enhances the Quality of Life of the ageing clients with disabilities? - How does this collaboration supports the professionalization of the staff? - What are the effects for society? A concrete methodology has been developed to support ageing clients in the service for the disabled (creating chances for the clients to stay at home as long as possible, by outreach and support by the service for the elderly) and to support clients with disabilities in the mainstream service for the elderly (by supporting the staff by the service for the disabled). As both organizations share a similar belief on inclusion, quality of life and community based support, and as available skills and competencies in both organizations are complementary (both necessary to deal in a qualitative way with the needs of ageing persons with disabilities in the mainstream, community based services), this partnership has been formalized: by doing so, a condition was created that support the intention to realize an inclusive approach, starting from the ageing in place principle. In the disability field, facilities are faced with a growing number of ageing clients. The staff of this facilities has a lot of disability-specific knowledge, but is not trained in a medical oriented approach, necessary to deal with fysical and mental needs. When vzw den achtkanter is faced with challenges/new support needs of a certain client related to ageing, the coordinator of Sint Vincentius supports the staff that supports the ageing client, by sharing tips, tricks and insights to enable the staff to support the ageing client. The goal is that to support the client as long as possible in the living situation he prefers. When – at a certain moment - the needs of the ageing client exceed

	the means of the organization (staff, competencies, architectural,…), this client can move to the mainstream service for the elderly. This is just as it is the case for everyone in society who is becoming older and needs specific support and can’t stay at home anymore. From that moment on, the team of the service for the elderly is supported by the facility for the disabled, sharing disability-specific knowledge. We believe that this exchange of competencies – beyond the borders of the different fields – enhances competences and community based support.
DESCRIPTION OF TARGET GROUP	- Staff of the mainstream service for the elderly - Staff of the organization for people with disabilities - Disabled ageing people
MEANS/METHODS OR TOOLS USED	Outreach, VET, case management, intervision, supervision
SKILLS INVOLVED FOR THE CAREGIVERS	Mind set, beliefs, attitudes, skills concerning qualitative ‘handicap specific’ support Idem concerning dementia, palliative care, ethics, physical needs
ATTITUDES INVOLVED FOR THE CAREGIVERS	Belief system that incorporates the full participation of all citizens, independent their physical, mental or intellectual condition
RESOURCES NEEDED	Actually, there is no financial support for this collaboration.

5. A new inclusive professional profile

NAME OF HOST ORGANISATION/INSTITUTION	**VZW DEN ACHTKANTER, KORTRIJK** (B)
TITLE OF THE GOOD PRACTICE	A new 'inclusive' professional profile
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Making explicit the 'new' competences of those who care for and support disabled clients in an 'inclusive' way
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Inclusive, community based support challenges those who are actively involved in caring and supporting client. Staff needs to make a transition from a single focus on the support needs of the client, to a multi-faceted focus, taking into account - in addition - those items that support clients to be part of and actively participating in society as a citizen
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The UN convention, and consequently the Quality of Life model, was the starting point of a discussion, resulting in a document 'Competences and a new profile for coaches' produced by the members of the 'commission Inclusion' of the Flemish umbrella organization Vlaams Welzijnsverbond. What are competences of a 'coach' who wants -to realize an individualized support, -to take into account the power that is present in the client (his talents and potential) and the power of the social network, -to give tools to the client to be the director of his life, and -to use community based services whenever possible. This exercise forced the commission -to reflect on the real nature of handicap specific support, -to look for ways to invest in the relationship between the client and his environment (and not in the relationship between the caregiver and the client – without neglecting the importance of a qualitative relation between client and caregiver), and -to detect the necessary new skills related to a social supports model (coordinate, facilitate, outreach…). Key competences are linked to : empowerment, a holistic approach and taking into account / and support the social context, building bridges/community building .
DESCRIPTION OF TARGET GROUP	- formal and informal caregivers - curriculum developers - HR policy makers

6. Experiental learning in care ethics lab

NAME OF HOST ORGANISATION/INSTITUTION	**SINT VINCENTIUS, KORTRIJK (B)** **STIMUL: CARE-ETHICS LAB, MOORSELE (B)**
TITLE OF THE GOOD PRACTICE	Experiential learning of empathy in a care-ethics lab
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Stimulating care providers and students to reflect critically on care practices, Creating an educational/pedagogical context in which 'good care' can be taught and cultivated.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	In six European countries, empirical research showed that older people perceive that 'good care' is at stake in a number of daily care interactions. In day-to-day instances – such as receiving courteous treatment, having one's privacy respected, avoiding being reduced to a 'problem', and being allowed to choose for oneself – older people report experiencing that care providers knowingly or unknowingly contribute to their vulnerability. The extent to which care providers are sensitive to older adults' sense of vulnerability is crucial to achieving 'good care'. Good care includes everything that care providers undertake in order to respond to the vulnerability of others. Showing empathy to the other and tuning in to the integral well-being of this person are essential hallmarks of good care. This means, among other things, being attentive to the person and providing more than the minimal needs for an older adult's situation. In this sense, good care includes a number of activities and attitudes that begin with care providers' attempts to understand older adults' situation, perspective, and vulnerability, and then to deal with these appropriately. From the above consideration, the extent to which care providers understand the vulnerable situation of care receivers and act on it determines whether good care is achieved. With reference to virtue ethics, we have argued previously that an attitude of empathy for the other must be acquired and cultivated. Moreover, care providers can acquire this attitude through practice, adjusting their care accordingly. If this attitude is not taught, or if it is rarely or superficially taught, through education and training of care providers, there is a risk that care is reduced to nothing more than the execution of technical acts and interventions. The care provider focuses mainly on these technical actions and the care-technical question 'Has everything been done correctly?' rather than on the care-ethical question 'Has everything been done to benefit the care receiver?' In 2008, the care-ethics lab sTimul was established in Flanders, Belgium, to promote ethical reflection, to stimulate a caring attitude and to generate empathy in care providers and care providers in training. The initiative for setting up a care-ethics lab was undertaken by a few nursing schools and nursing homes. The sTimul care-ethics lab represents a collaborative project between the education and care sectors. The sTimul lab offers several educational tools, among which are an empathy session, workshops, and learning trajectories.

SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	To generate empathy in the care of vulnerable older persons requires care providers to reflect critically on their care practices. Ethics education and training must provide them with tools to accomplish such critical reflection. It must also create a pedagogical context in which good care can be taught and cultivated. The care-ethics lab ‘sTimul’ originated in 2008 in Flanders with the stimulation of ethical reflection in care providers and care providers in training as its main goal. Also in 2008, sTimul commenced the organization of empathy sessions as an attempt to achieve this goal by simulation. The empathy session is a practical and fairly straightforward way of working to provoke care providers and care providers in training to engage in ethical reflection. Characteristic of the empathy session in the care-ethics lab is the emphasis on experience as a basis for ethical reflection.
DESCRIPTION OF TARGET GROUP	Care providers + students
MEANS/METHODS OR TOOLS USED	An empathy session in sTimul consists of an internship, followed by discussion and, finally, a return day or time for ethical reflection. The internship component is a simulation exercise lasting two days and includes one overnight stay. Because the participants are students or experienced care providers, the empathy session is two-dimensional. First, the experienced care providers have the opportunity to play the part of an older resident according to a specific resident profile in a simulation exercise. These care providers are all working in residential care settings for older people. They are registered nurses or allied with health and social work professionals. They are assistant nurses, managers, or professional nurses and will have different lengths of service. Second, a group of nursing students are given full autonomy in planning and carrying out the care process for the simulation residents. These groups are always students from the same school and the same degree course. They are final year nursing or nursing assistant students. The only ‘care’ experience most of the students have is during their hours of internship. Some students – especially nurses who are seeking to upgrade their qualifications – are older and have previous experience in health care. For both groups, students and care providers, participation in the empathy session is not obligatory, but is voluntary. Two educational assistants from the care-ethics lab are responsible for preparing and supporting the empathy session.
SKILLS INVOLVED FOR THE CAREGIVERS	Critical reflection on care practices Giving good care in order to respond to the vulnerability of others
ATTITUDES INVOLVED FOR THE CAREGIVERS	Experiential learning of empathy Ethical reflection
RESOURCES NEEDED	An educational/ pedagogical context in which good care can be taught and cultivated

7. Nursing students attitudes towards elderly

NAME OF HOST ORGANISATION/INSTITUTION	UNIVERSITY COLLEGE GHENT (B) FACULTY OF EDUCATION HEALTH AND SOCIAL WORK)
TITLE OF THE GOOD PRACTICE	Enhancing nursing students attitudes towards elderly by education (ANSE)
GENERAL OBJECTIVE OF THE GOOD PRACTICE	
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	In general, population is ageing
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	In this presentation, the ANSE project (Attitudes of Nursing Students towards Elderly) is discussed. Belgium, like the rest of Europe is confronted with population ageing. As a consequence, nurses specialized in elderly care are needed. On the other hand, the university college Ghent saw decreasing numbers of nursing students interested in geriatric care. In response to this, the project ANSE was started. First, the content of the course gerontology in the first year of the curriculum was changed. Topics like incontinence, ostheoporosis, dementia, arthosis were replaced by topics focusing on healthy ageing. Before the course started and after the end of the course, the ANSE was used in order to capture students attitudes towards elderly. Each year and this from 2007 on, a significant positive evolution of the students attitudes was found. Moreover, students did not agree with the statements that caring or elderly was unattractive or less prestigious. However, these results did not result in higher numbers of students enrolled in the specialized program geriatric nursing. Since 2011, this specialized program is abandoned and each student must follow a general program. As a consequence, this positive evolution in attitude is applicable for all nursing students. As the number of older people are increasing in both the community and on hospital wards, this result is encouraging. Conclusion: education can positively influence nursing students attitudes towards elderly
DESCRIPTION OF TARGET GROUP	Students, future nurses

8. Transition from a medical to a social inclusion model

NAME OF HOST ORGANISATION/INSTITUTION	SINT VINCENTIUS, KORTRIJK (B)
TITLE OF THE GOOD PRACTICE	Transition from a medical to a social inclusion model in elderly care
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Improving quality of life of vulnerable elderly people
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Scientific research - supported by resident satisfaction surveys, the experiences on the work floor as well as evolving social tendencies - demonstrates that a personal, social and existential approach supersede the medical support in order to complete the final stage of life in a, for the resident, meaningful way.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The results of a research on vulnerable elderly (performed by the “Sociaal en Cultureel Planbureau Den Haag in 2011) prove that the elderly attribute a larger importance to the quality of life (e.g. the living environment, friends as well as free time) over dealing with their medical problems. The “WeDO” initiative (a European project on the life quality of elderly who are in need of long-term medical care) describes how giving meaning is enhanced by the inner force empowered by a contribution of the social network as well as a professional setting with a focus on giving a positive image to elderly care. This is further enhanced by working on an individual basis in small-scale projects. As such an individual approach is the foundation to person-centric care in an agreeable life and living environment. Within our organization Sint Vincentius we have evolved from a setting with 2 large departments to an organization with 6 living units where both the medical and logistical staff is linked to a specific living unit. This allows the staff to create an individual relationship with each of the residents in order to understand their vulnerabilities and needs but also to create opportunities to contribute to the residents wellbeing. Because of this approach we can enable every resident to participate to the daily activities in a way they are comfortable with. Our person-centerd approach will reach new levels with our move to our new residential facilities on campus Houtmarkt in 2016. The new construction allows a transition to 10 living units with only 15 residents per unit. This allows for an even more individual approach. Together with the move our intake procedure will also be adapted in order to provide the best care possible. Today we focus mainly on the medical history of the resident; in the future more attention will be given to the social background and experiences of the new resident. An inclusive situation will be further achieved through a temporary stay in a “orientation house” which will allow us to learn who the resident really is.. After this orientation phase and based on his social background, their life story as well as how they perceive meaning, they will be assigned to the living unit that best fits their needs and expectations.
DESCRIPTION OF TARGET GROUP	Elderly at risk

MEANS/METHODS OR TOOLS USED	Learning community Satisfaction surveys for residents as well as staff Appreciative Inquiry Prezo 360° feedback
SKILLS INVOLVED FOR THE CAREGIVERS	Social/educational skills (agogic skills)
ATTITUDES INVOLVED FOR THE CAREGIVERS	Openness and flexibility to participate in small scale care
RESOURCES NEEDED	Required knowledge and skills, strategy and vision

9. Maatjes vrijwilligers zorg

NAME OF HOST ORGANISATION/INSTITUTION	VRIJWILLIGERSWERK ROTTERDAM
TITLE OF THE GOOD PRACTICE	Maatjes Vrijwillige Zorg (MVZ)
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Supporting elderly people and vulnerable locals and people with a small social network through the deployment of a volunteer as a buddy.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Buddy projects and the help volunteers can give to vulnerable people in Rotterdam is highly developed and of great importance to the city and the welfare of its citizens. MVZ is an example of a well-organized system of volunteers which can be inspirational for the other organizations of the TRIADE project.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	MVZ is a collaboration of nearly 45 Rotterdam voluntary organizations. These organizations offer people from Rotterdam who need a helping hand, for whatever reason, volunteer assistance in the person of a buddy. A buddy is someone who wants to support another voluntary and giving him or her attention for a longer period of time. Buddies visit lonely elderly at home or walk with them and they accompany people to the hospital. A buddy can also do practical things, like going to the store together, but pals also provide homework-assistance to children and help others with their administration and finances. Volunteers want to participate because they find it important to play a part in society. At the same time this care can never be a substitute for the responsibility that people have for their own lives. MVZ enables organizations, who organize care for each other and volunteer work, to meet, strengthen and learn from each other so that optimum shape is given to civil society. A society in which everyone participates. **Hotline** The most important daily activity of MVZ is the settlement of the incoming requests for help. Anyone who has a question can contact the contact point and one of the employees of MVZ helps them. The questions come from relatives or friends and, increasingly, carers and professionals such as social workers, VraagWijzer (an office for information for citizens in Rotterdam) and other members of the community teams, as well as caregivers and physiotherapists. The question is clarified and described, we look at which of the MVZ organizations can accommodated the question. MVZ does not have its own volunteers. **Knowledge and experience** MVZ is a network where voluntary organizations share

	knowledge and experience during several meetings in a year. MVZ also organizes activities such as a conference or a buddy market. We try to keep organizations informed of current developments and organize, as necessary, theme-meetings about these developments. **Student volunteers** MVZ has close contacts with the university of Inholland. First-year students can do their internship in the form of student volunteering at MVZ organizations. Students thus make a first experience in practice and for organizations is a welcome addition to their volunteer base. Every year more than 300 students are mediated in this way. **Education** For buddies, family carers and for professional coordinators MVZ organizes workshops, theme-meetings and courses. The topics of the activities are often raised by the MVZ organizations. **Culture as a form of appreciation** In appreciation of all their efforts volunteers van, along with their buddy, go to concerts and performances with discount. This stems from a collaboration with the Ro Theater, Scapino Ballet, Theater Zuidplein and De Doelen.
DESCRIPTION OF TARGET GROUP	Every citizen from Rotterdam who could use a helping hand, like those who have a limited social network, the elderly, the vulnerable, people with disabilities or who are socially isolated.
MEANS/MEHODES OR TOOLS USED	There is a Central Point where care needs can be reported by people who are seeking help themselves, but also friends, family and professionals such as social workers and caregivers. MVZ clarifies the question and looks for the buddy-project that fits best with the question. The buddy-project matches a buddy with the person who needs help.
SKILLS INVOLVED FOR THE CAREGIVERS	Volunteers who as a buddy must be interested in other people. They have the ability to listen to others and to help them advance in life. They have to have sincere attention for others.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Volunteers as buddies started have an open mind with regard to the other person, but at the same time should keep an eye on their own limitations.
RESOURCES NEEDED	For MVZ: 1. Coordination of the hotline and maintenance of the network of organizations. 2. Exchange of knowledge and experience, organizing meetings of coordinators 3. Training and thematic meetings. For the buddy projects: 1. Professional coordination of the project 2. Professional supervision of the volunteers 3. Education and training

10. Methodical support – urlings method

NAME OF HOST ORGANISATION/INSTITUTION	STICHTING PAMEIJER
TITLE OF THE GOOD PRACTICE	"Respectful and methodical support of demented, cognitively disabled elder people”
GENERAL OBJECTIVE OF THE GOOD PRACTICE	How does the professional caregiver perceive people with a cognitive disability when they are/become elderly? What conditions are required to support these clients?
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	In addition to the GP in Kortrijk (inclusive support disabled ageing people) we have selected this GP. It shows how Pameijer trains their professionals so that they are better equipped to handle ageing people with disabilities.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	People with a cognitive disability are aging. The population of elderly with cognitive disabilities is growing. Many of these people encounter the regular obstacles and aches that come with age. By educating the caregivers, they become aware of the fact that this group of clients needs specific support. They learn how to recognize the signs of aging and how to interact with the client. A methodical and respectful approach towards this client group is part of the education program. Pameijer is strongly oriented towards helping her clients develop and be more self-reliant, to help diminish their dependence on professional care and to help them contribute to society. Self-management, talent development and temporality are the core values of the organization. In the guidance of a person entering its final stage of life, we will have to look at them differently. As with virtually every other human who’s aging, someone's need for development changes and sometimes they become more reliant of others. How do you deal with that? How do you support someone in this aging process and how aware are you of that process? Old age is (generally) defective. How do you keep quality of life as well as possible, and what does aging mean? This is different for every person, just as learning is different for every child. Guidance and support for this "group" of elderly, which is growing bigger, also requires an individual approach. A conscious, informed approach with varying targets, tailored to a person's life and opportunities. By use of the "Urlings Method", employees of Pameijer are taught to view a person’s situation carefully and respectfully when it comes to aging. This helps caregivers make their support suit the needs of the client.
DESCRIPTION OF TARGET GROUP	Caregivers, managers and scientific pedagogues.
MEANS/MEHODES OR TOOLS USED	The “Urlings Method”
SKILLS INVOLVED FOR THE CAREGIVERS	Knowledge of aging and dementia in people with cognitive disabilities.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Awareness of the process of aging, respect for the individual client.
RESOURCES NEEDED	None.

11. The memory palace

NAME OF HOST ORGANISATION/INSTITUTION	SOL
TITLE OF THE GOOD PRACTICE	The Memory palace
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Goals: • Improving the quality of life for people with dementia; • Reducing the burden of the caregiver and promote their health and well-being; • Preventing or delaying admittance of a person with dementia in a nursing home.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	We want to show how a relatively simple local intervention can contribute to the quality of life for people with dementia and their (informal) caregivers.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The Memory palace is an accessible meeting place for elderly with early stages of dementia and their caregivers. In 2014, SOL Elderly has successfully launched the first Memory palace. The SOL model Memory palace is a combination of elements from the meeting centers for people with dementia, as developed by VU Medical Centre in Amsterdam and the 'Odense house' as developed in Denmark. The fixed program components of which efficacy has been proven are copied from the meeting centers for people with dementia: music and movement. From the Odense House model has been adopted its own activities where participants are encouraged to. Around it the support of the elderly and their caregivers. In the north of Rotterdam the first Memory palace started. In this area about 359 dementia patients are estimated to be living on their own. This has major implications for the environment: caring for the resident with dementia often comes down to the immediate area. Today, there are also Palaces of Memories in IJsselmonde and Charlois and Rotterdam Overschie. Each location has place for up to 20 elderly. In all these areas are also one or more forms of professional psycho-geriatric day care. The Memory palace is complementary and may reduce the step to formal day care in the future. The Memory palace provides support to people with early stages of dementia and their caregivers. Easily accessible, close to home, in a warm environment and all under one roof. The Memory palace provides a place for informal care to participants. Partners, other family members, neighbors are actively involved in the daily activities if they want to, but it can also be a relief for these people: a moment free of worry and responsibility. Topics and activities suggested by the participants are included in the program. A particular activity, a game for example, can also be organized at home, by the caregiver or volunteer. The activities target memory

	and reminiscing in order to activate the client. An integral part is an hour filled with music and movement, led by a teacher. A great added value of the Memory Lane is the power of shared achievement: the elderly together with their caregivers, volunteers and interns. By visiting the Memory Palace once a week, elderly can break the old pattern of retreating, becoming more and more vulnerable and increasingly burdening the informal caregivers. People on average live with dementia for eight years. The Memory Palace proves that we can improve the quality of life for people with dementia in the early stages of this disease.
DESCRIPTION OF TARGET GROUP	Independently living elderly in the first stages of dementia and their caregivers.
MEANS/MEHODES OR TOOLS USED	The memory Palace provides support to people with early dementia and their caregivers. Easily accessible, close to home, in a warm environment and all under one roof. Memory Lane provides a place for informal care to participants. Partners, other family members, neighbors are actively involved in the daily activities if they want to, but it can also be a relief for these people: a moment free of worry and responsibility. Topics and activities suggested by the participants are included in the program. A particular activity, a game for example, can also be organized at home, by the caregiver or volunteer. The activities target memory and reminiscing in order to activate the client. An integral part is an hour filled with music and movement, led by a teacher. A great added value of the Memory Lane is the power of shared achievement: the elderly together with their caregivers, volunteers and interns.
SKILLS INVOLVED FOR THE CAREGIVERS	Collaboration and networking with other professionals and volunteers Persuasiveness creativity Communication skills Perspective Flexibility Rest Humor Group dynamics
ATTITUDES INVOLVED FOR THE CAREGIVERS	Wanting to learn, not wanting to know everything, focus on individual human being, optimism, openness, compassion, welcoming of diversity.
RESOURCES NEEDED	A location with informal atmosphere for one day a week; Budget for coffee, tea, water; Resources for the cost of the vocals and movement teacher 1.5 hours per week; Means for the cost of a professional supervisor of the elderly and of volunteers; Budget for the expenses of volunteers.

12. Zorgbelang – caring by dialogue

NAME OF HOST ORGANISATION/INSTITUTION	ZORGBELANG ZUID-HOLLAND
TITLE OF THE GOOD PRACTICE	“Samen zorgen: beleef de dialoog” - Taking care together the dialogue.
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Better coordination between formal care (professionals), and informal care (family carers)
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	This good practice connect formal and informal care by learning together en from each other. We think this is very important to improve the care for the clients and strengthen the position of the informal caregivers. This GP has been implemented in a nursing home, but can also be applied in different settings.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The care of family and friends does not stop at the front door of the nursing home. Relatives and other members of the clients network are nowadays as much as possible involved in the care of their loved ones. To take care together, professional and informal care, it is important that there is a good dialogue at the work floor between nurses, family members and the client. By keeping touch with each other, good listening and asking the right questions it’s possible to improve the care around the residents. Contacts are more enjoyable and residents feel more at home in the care center. Family members are more willing to lend a hand when the contact with the professionals proceeds pleasant. A care facility has asked Zorgbelang South Holland to develop a customized workshop for family and professionals together. This concerns in particular the care of psycho-geriatric residents. Most workshops and training sessions in which the dialogue is a central theme, are aimed at professionals: how do I deal with the family? A workshop in which both perspectives (family and professional) are represented, is innovative. Based on input from separate group discussions with managers / team leaders, nurses / carers and family members the workshop is developed. Dialogue and progress-focused communication techniques are central items in the workshops. Below you can find the structure of the workshop. It consist of two sessions with the following topics: • Participants, professionals and family members, get simple practical guidelines which are widely practiced. • Participants work with their own cases. • Participants practice what they need in practice and get specific feedback. • Coaches have much experience as a trainer, but also in contacts with clients and family members. • Trainers also work as a trainer-actor so that the

	participants can practice their skills in a safe setting. **Program** Day 1: • The importance of listening • Understanding the language of someone else • Join the other one • A request to someone • Saying no, explain your limits and stick to it • Giving a clear message • Working with real-life situations Day 2 • Bringing a difficult message • Speaking to family members who complain • Supporting a family member • Handling your emotions • Give feedback, also to colleagues • Steering the conversation • Work with real-life situations The evaluations showed that the participants have learned very much from each other in the workshop and learned many things which are useful in practice. The workshop can be customized as needed for other care organizations.
DESCRIPTION OF TARGET GROUP	Family of residents in nursing homes and professionals
MEANS/MEHODES OR TOOLS USED	Interview techniques
SKILLS INVOLVED FOR THE CAREGIVERS	Communication skills Empathy Submitting a request Giving feedback Saying no Collaboration
ATTITUDES INVOLVED FOR THE CAREGIVERS	An open attitude, willingness to learn new things and seeking a connection with the other
RESOURCES NEEDED	Training folder Roleplay Practical situations Movie about communication Flip over and post its

13. Self sufficiency matrix

NAME OF HOST ORGANISATION/INSTITUTION	MUNICIPALITY OF ROTTERDAM
TITLE OF THE GOOD PRACTICE	The Self-Sufficiency Matrix (SSM)
GENERAL OBJECTIVE OF THE GOOD PRACTICE	The Self-Sufficiency Matrix (SSM) is a tool that enables practitioners, policymakers and researchers in public healthcare, social services and related work fields to assess the degree of self-sufficiency of their clients simply and comprehensively.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Complex concept, with a simple assessment. Easy to adopt in other countries.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The Self-Sufficiency Matrix – Netherlands versions (SSM-NL) has 11 domains for which the degree of self-sufficiency is assessed. These domains are closely interlinked, as they all relate to daily life, but they are defined in such a manner that they do not overlap at all or only slightly. The domains of the SSM are: Income, Day-time activities, Housing, Domestic relations, Mental health, Physical health, Addiction, Daily life skills, Social network, Community participation, and Judiciary. These are the essential and non-surplus areas that determine the effectiveness, productivity and quality of life for every adult (in Dutch society). The 11 domains are set out in rows, tiled horizontally. The five answer options are in columns, tiled vertically. This creates a matrix with 55 cells. Criteria have been prepared for every cell that further specify the answer options for the domain under assessment and support the assessor in rating the self-sufficiency for that domain. These criteria help the user to understand what the developers mean by ‘not self-sufficient’ for the domain Income (‘inadequate income and/or spontaneous or inappropriate spending, rising debt’). The eventual rating consists of 11 times a score between 1 and 5. The SSM enables the assessor to obtain a relatively simple and comprehensive overview of a complex concept with various and wide-ranging aspects that play an important role in the degree to which a person can lead a productive and good-quality life - self-sufficiency.
DESCRIPTION OF TARGET GROUP	People who benefit from social services can be assessed with the SSM. The assessment can be used in various ways
MEANS/MEHODES OR TOOLS USED	Completing the SSM can take place following an intake, progress or exit interview. The interview topics need to cover all the domains of the Self-Sufficiency Matrix. The assessment can be used in various ways Screening A tool to chart the self-sufficiency of the individual client The client is rated once with the SSM; the score provides insight into the self-sufficiency. Progress and development A tool to determine the development of an individual client The SSM is used at least twice for a client at different times.

	The difference between two scores provides insight into the progress and development of the client. Allocation A tool to assign an individual client to an intervention The client is rated once with the SSM. If the score complies with a criterion that was set for a specific intervention, the client can be assigned to that intervention. Set treatment targets A tool to set treatment targets for the individual client. The SSM is used once with a client. The practitioner determines the probable achievable self-sufficiency and expresses this as a virtual score for a future measurement moment. Routine Outcome Monitoring (rom) A tool to monitor the results and outcome of an intervention. The SSM is used at least twice for a group of clients that is assigned to a certain intervention. The effect of the intervention on the group can be evaluated by comparing group scores over time. Guidelines for interventions A tool to set targets for an intervention. Care providers can express the anticipated results of an intervention in (difference) scores on the SSM. Performance agreements with financers of care can be specified and standardized in this manner.
SKILLS INVOLVED FOR THE CAREGIVERS	Caregivers should have a good understanding of self-sufficiency as outcome. Caregivers who use the SSM are recommended to practice its use a few times. There are strong indications that this improves the reliable use of the SSM.
ATTITUDES INVOLVED FOR THE CAREGIVERS	None, the SSM is not mend to influence the attitude of caregivers (not directly)
RESOURCES NEEDED	No special resources needed
NOTES	We use the following definition of self-sufficiency: Self-sufficiency is the ability to carry out activities of daily living independently. These activities of daily living pertain to different domains. For example, daily life requires actions to provide for an income, to remain physically and mentally healthy or to maintain a supportive social network. Activities of living also include organizing the right help when a need arises that cannot be met by the person themselves. For example going to the GP in time in case of illness, or asking professional advice with completing a tax return. The degree of self-sufficiency is therefore an outcome of personal characteristics, such as skills, personality and motivation and environmental characteristics, such as culture, economy and infrastructure that enable a person to provide for their own basic life needs to a greater or lesser extent.

14. Social family home

NAME OF HOST ORGANISATION/INSTITUTION	CONSEIL DEPARTEMENTAL DU VAL-DE-MARNE
TITLE OF THE GOOD PRACTICE	Social Family Home for elderly and disabled people
GENERAL OBJECTIVE OF THE GOOD PRACTICE	- Enhance the quality of life of elderly and people with disabilities; - Diversify the support of elderly and disabled people in Val-de-Marne; - Allow elderly and disabled people to age in the place of their choice; - Allow any person interested to support at his/her personal home elderly or people with disabilities and who fulfils the conditions of good care at home, to have remuneration for this support.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	This practice was chosen because it could be an alternative to institutional care in France, and particularly in Val-de-Marne. Social Family Home for elderly and disabled people could be a relevant and complementary solution to the current offer of support.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	**What is Social Family Home for elderly and disabled people?** The social family home is a national device representing an alternative to institutionalization of elderly and disabled elderly. Halfway between the institutionalization and home care, the social family home is a solution for people who can not or do not wish to live any more alone in their homes and prefer a family surrounding to an institutionalization. Elderly or disabled interested by this solution joint a family in the frame of social family home, and they take part of this family and participate in the activities according to their abilities. The social family home hosts elderly over 60 and disabled people over 20 years in permanent, temporary or sequential way. The social family home is organized in the way to allow elderly or people with disabilities to stay in their surroundings and to maintain ties with their previous environment. This geographic criteria is taken into account during the selection of families. Social family home is especially for people with a minimum of autonomy. Living in a family surrounding, having a home compatible with the needs related to age or disability, benefiting from a supportive and stimulating presence and personalized support, such are desires of many elderly and disabled who cannot or no longer wish to remain in their homes. Social family home caregivers interested in this way of support of elderly and disabled people have to be authorized by the Departmental Council of Val-de-Marne, and this authorization brings them a salary and reimbursement of other expenses. Also, the Departmental

Council of Val-de-Marne is in charge of control of the quality of support by visiting the social family homes and by interviewing the caregivers and elderly and disabled.

At last observation realized by Departmental Council of Val-de-Marne, it appears that the social family home is a very good solution particularly for isolated elderly and disabled people:

- Elderly who have no children and family looking for a family environment and who exclude completely the possibility to go to the institution.
- People with disabilities who have always lived with the family at their homes or have been in institution for a long time, and who wish to find a more peaceful environment.

Today, there are 40 social family homes in Val-de-Marne. 9 ageing people with disabilities over 60 years old are hosted in social family homes.

Legal statute of Social Family Home caregiver:

Social Family home are authorized and supervised by the Departmental Council in their department (county).

The Social Family Home caregiver signs the contract but this contract is not an employment contract.

They contribute to divers insurances (sickness, maternity, disability and old age insurance).

Hosted elderly and disabled people and Social Family Home caregiver sign a written contract. This contract specifies the nature and financial conditions of the support. This contract also includes the rights and the obligations of both parties and the rights to annual leave and alternative arrangements to continue the support.

Educational training for Social Family Home caregivers

The current law regulating the social family homes requires basic initial and continuous educational training of social family home caregivers but doesn’t give the details (the clarifications should be reviewed at national level very soon).

The educational training at destination of social family home caregivers are:

- training of first help;
- workshops of exchange of practices based on:
  - Analysis of practices
  - the Department organize the intervention of professionals on various themes (good treatment, art therapy, professional discretion ...)

The legislative framework regarding training is developed at national level, while the Department (county) has a choice to organize content and form and content of training.

DESCRIPTION OF TARGET GROUP

Elderly or people with disabilities at Social Family Home:

Elderly people over 60 and disabled people over 20 years are hosted in social family homes in permanent, temporary or sequential way.

Elderly or disabled must be sufficiently autonomous and does not need medical supervision and constant care.

	Before elderly or people with disabilities go to social family home, there is a period of preparation and adaptation. Also, there is a medical and social monitoring provided by a team of social and medical staff. **Social Family caregiver:** The social family home caregiver is authorized by the Departmental Council for a period of five years. This authorization is granted after the evaluation of material and hosting conditions. Moreover, social family home caregiver must receive initial training before he starts to support elderly or disabled people at home. The social family home caregiver must be able to provide a single room for a minimum of 9m2 for a single person and 16 m2 for a couple. It must also ensure health, safety and physical and morale well-being of hosted elderly or disabled people in order to create all conditions to participate in family life. The social family home caregiver must ensure continuity of support by offering all kind of alternatives during its absences (holidays, training, illness ...). Also, the social family home caregiver must ensure the medical and social support of the hosted people at his home.
MEANS/MEHODES OR TOOLS USED	Different trainings and sharing of practices between social family caregivers are available in order to insure wellbeing of hosted elderly or disabled people. The practices of social family home caregivers are constantly evaluated in order to optimize the support.
SKILLS INVOLVED FOR THE CAREGIVERS	Beyond fulfilled material conditions, the social family home caregiver should love human beings because he is responsible of their lives. He must ensure a supportive and stimulating presence and personalized support.
ATTITUDES INVOLVED FOR THE CAREGIVERS	- To be kind and affective person; - To have sense of listening and sharing; - To be able to adapt; - To be able to collaborate; - To be respectful
RESOURCES NEEDED	**For social family home caregiver:** - Have a safe and accessible environment, a single room with a minimum of 9m2 and 16m2 for a couple, medical and social support at caregiver's home, by medical social workers teams.

15. Internship of future professionals of foreign origin

NAME OF HOST ORGANISATION/INSTITUTION	CONSEIL DEPARTEMENTAL DU VAL-DE-MARNE
TITLE OF THE GOOD PRACTICE	Training with internships for future professionals in the field of elderly and disability allowing their socio-professional integration
GENERAL OBJECTIVE OF THE GOOD PRACTICE	- Create a quality support of elderly and disabled; - Meet the needs of home support services to have qualified staff; - Meet the needs of training and socio-professional integration of a foreign public.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	This training with tutoring internship is an example of training of future professionals supporting elderly, disabled and ageing disabled people in their homes or in institutions. Future professionals are persons of foreign origin, with a small qualification or no qualified at all, wishing to support elderly and disabled people. This kind of practices is not yet presented in the frame of TRIADE.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	In order to resolve difficulties in recruiting of qualified professionals at home support services, departmental Council of Val-de-Marne has implemented the training with tutoring internship to enable persons with foreign origin, with a small qualification or no qualified at all, but willing to support elderly or disabled people, to integrate a training with an internship for 3 months to learn skills and attitudes. This action is based on three objectives: 1. Create a quality support of elderly and disabled; to the user 2. Meet the needs of home support service to have qualified staff; 3. Meet the needs of training and socio-professional integration of a foreign public. Future trainees have previously achieved the professional language training (French professional language for 60 trainees per year), also implemented by the Departmental Council of the Val-de-Marne, allowing them to develop and to improve language skills considered as a real barrier to socio-professional integration. In the end of language training, trainees have the opportunity to go on training with internship taking place in home support services or in institutional accommodation for dependent elderly (nursing homes), in institutions for disabled people. From 2013 to 2015, 65 trainees could benefit of this training with internship (35 per year). In 2015, 34 trainees have achieved the training with internship and 21 among them have found work immediately in the different structures for elderly and disabled. The training with internship is financially supported by the Departmental Council of Val-de-Marne (internship salaries of trainees, cost of coaching, cost of training of tutors).

	The aim of tutoring internship is that the organization (home support services or in institutional accommodation for dependent elderly-nursing homes, in institutions for disabled people) hosts a trainee allowing him to observe the work and to participate and perform tasks. For two months, the trainee is always surrounded by one of the staff, and on 3rd moth of internship, the trainee could accomplish the tasks by himself. The trainee is evaluated not only by his mentor but also by other stakeholders. **Duration of training with internship**: 3 months of internship with one day training per week (housing maintenance, kitchen, gestures and postures, Alzheimer, death of elderly or disabled and how to deal with, professional posture, intercultural relations, professional writing, etc.). An additional day of training is programmed during the first and the last week, a total of 105 hours of training. The intern working hours depend on the applications and availability of trainees and practices of the host organization. In 2016, the duration of the training and internship has been modified in order with putting accent on training in order to allow trainees to obtain qualifications and to sustain their employment.
L with	Future professionals supporting elderly, disabled and ageing disabled people in their homes or in institutions. Future professionals are persons of foreign origin, with a small qualification or no qualified wishing to support elderly and disabled people Elderly, disabled people and ageing disabled people
MEANS/MEHODES OR TOOLS USED	This action cannot be able without a good networking of all actors in social, elderly and disabled field.
SKILLS INVOLVED FOR THE CAREGIVERS	Skills needed to support elderly and disabled; Communication skills
ATTITUDES INVOLVED FOR THE CAREGIVERS	To love human being, to be patient, to have capacity to understand and to listen, to be open minded.
RESOURCES NEEDED	Training is realized by training organization Brigitte Croff Conseil et Associés, and internships take place at home support services or in institutional accommodation for dependent elderly (nursing homes) and in institutions for disabled people.

16. Informal care in Val-de-Marne

NAME OF HOST ORGANISATION/INSTITUTION	DEPARTMENTAL COUNCIL OF VAL-DE-MARNE
TITLE OF THE GOOD PRACTICE	Informal care in Val-de-Marne
GENERAL OBJECTIVE OF THE GOOD PRACTICE	- To support the informal caregivers in their administrative procedures to access to various aids and trainings through coordination of actors from social, elderly and disability fields in Val-de-Marne; - To allow wellbeing of informal caregivers and theirs relatives.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Following the meeting in Rotterdam which focused on informal care, we considered that it will be appropriate to present, as a part of the departmental policy of support of caregivers (informal and formal), a specific action based on information and exchange between informal and formal caregivers. This action allows to reach as more informal caregivers as we can in order to improve their care, their wellbeing and wellbeing of their cared elderly and disabled people.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	Forum of caregivers is an event organized annually by the Departmental Council of Val-de-Marne, in order to gather and to inform informal caregivers on existing devices and aids. Also, the forum allows to identify informal caregivers not registered until today in Val-de-Marne. In France, informal caregivers represent one person out of six. Many of them are unaware that they also have right to be supported. Caring for a person with reduced autonomy can lead to isolation and exhaustion. Health of caregiver and his wellbeing are essential to cared person. In 2016, forum of caregivers took place on 3th of October in the museum of Modern Art called MAC VAL allowing caregivers and their cared people to discover this adapted place accessible for everyone. Caregivers could come and participate with their cared relatives. During the whole day, the visitors (informal caregivers) meet professionals at the information points (stands) divided into a following universes: 1. Right: institutions and associations providing information about possible aids that they can benefit; 2. Health: hospitals, pension fund, security associations: all necessary resources to protect health; 3. Home: how to find help you need to live well at home; 4. Institutions: panel of services to support elderly and disabled people; 5. Active together: discussion with organizations that reflect and act to facilitate travel, leisure, meetings,

	training, etc. All organizations, associations and institutions participating to the forum, through a dynamic animation of their stands, valorize their actions and help informal caregivers to engage necessary steps to meet their needs (fulfilling shifts, making the appointments…). Two round tables are proposed for a collective exchange between visitors and professionals on two key life issues: - Announcement of loss of autonomy: from acceptance to adaptation; - How to hold together every day without feeling guilty? Each round table s preceded by 30 minutes piece of theater inviting visitors (informal caregivers) to share a moment of their life in order to go to the point of the subject and avoid too theoretical discourse. “Theater forum” (stile of theatre and debate) is the best way to let visitors to express themselves on stage with a moderation of a professional actor allowing the quality of exchanges and giving them concert answers to their concrete questions/problems that they could have (medical resources, respite, support group,…). Visitors can also discover various day activities available in workshops for caregivers and their cared people: 1. Workshops for all: adapted visits of the museum Mac Val, relaxation and music therapy, soft gym, good gestures of daily life, initiation on digital devices, workshops organized by Maison départementale pour personnes handicapées, workshop of how to adapt a home of elderly or disabled people. 2. Workshops dedicated to elderly and disabled people came with their caregivers: realization of a fresco with Mutual Self help Group of the municipality of Vitry sur Seine. A practical guide (brochure) has been made and given to caregivers gathering important information and resources for caregivers.
DESCRIPTION OF TARGET GROUP	Informal caregivers; Formal caregivers; Elderly and disabled people;
MEANS/MEHODES OR TOOLS USED	Gathering of all partners and stakeholders in social, elderly and disability fiels.
SKILLS INVOLVED FOR THE CAREGIVERS	Openness to the other, open mind, listening, exchange, cooperation
ATTITUDES INVOLVED FOR THE CAREGIVERS	It should be noted that some caregivers do not recognize themselves as such, do not ask for help and go to exhaustion. It is necessary that caregivers understand their position and their role of caregiver in order to take care of himself and his relative.
RESOURCES NEEDED	Material and logistical resources.
NOTES	Nearly 400 people came in Mac Val on 3th of October and hundreds of partners were mobilized to keep the stands, animate workshops, speak at round ables.

17. Units of life for ageing people with disabilities – Verdi

NAME OF HOST ORGANISATION/INSTITUTION	INSTITUTIONAL ACCOMODATION FOR DEPENDENT ELDERLY “VERDI”
TITLE OF THE GOOD PRACTICE	Units of life for aging people with disabilities
GENERAL OBJECTIVE OF THE GOOD PRACTICE	For clients: - Allowing ageing people with disabilities who were in institutions, to hold/continue or to recreate a social link. - Allowing ageing people with disabilities who stayed at home to break the isolation; - Maintain continuity of their life and social and cultural achievements; - Avoid multiple changes of accommodation; For families: - Ensure the relay, medical and social support when parents cannot continue to support their children ageing people with disabilities or after disappearance of parents; - Allow a joint institutionalization (parent / child);
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	In continuation of exchanges in Kortrijk based on the close relationship between institutions for disabled and elderly, we have chosen to present Units of life for aging people with disabilities within institutional accommodation for elderly. Units of life are, on one hand, result of a will of public policy to find a best solution to support ageing disabled people within an institution and, on the other hand, result of a collaboration between sectors of elderly and disabled (Departmental Council, municipality, institutional accommodation and ESAT-protected work places). The Department of Val-de-Marne tries to diversify its offer proposing a range of supports, in institutions or at home of ageing people with disabilities, or at Social family Homes in order to answer in the best possible way to the needs of this public.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	Population is ageing. Various progress of society, such as medicine and improvement of living conditions, contribute to extending life of the entire population, including people with disabilities. Thus, aging of people with disabilities (and their parents) inspire professionals to reflect how to support better needs of this public at home or in institutional accommodations (collective housing) within logic of the life course. The lengthening of life expectancy, due largely to improved care for people with disabilities creates a new need: - Institutional accommodation for ageing people with disabilities and ESAT-protected work places can no longer accompany people with disabilities unable to work or have reached retirement age. - Institutional accommodations for elderly have an expertise in the field of elderly care.

- Life in non-medical institutional accommodation cannot keep aging people with disabilities when their health requires significant medicalization.

The residence "VERDI" (institutional accommodation) was built with a section hosting aging people with disabilities as part of a partnership with the municipality Mandre les Roses and ESAT-protected work place ROSEBRIE in order to support their ageing residents.

Ageing people with disabilities who could no longer work there and who had a deterioration of their deficits needed for a more suitable solution and structure that could support them. At the time of the creation of the unity of life for ageing people with disabilities within residence "Verdi", this kind of structure was non-existent in Val-de-Marne.

Until today, 16 people live in Unit of life within residence "Verdi".

Their support is based on several dimensions:

- Emotional dimension: exchanges, discussions, family;
- Educational dimension: respect, exchange of information and knowledge, valorization, maintaining independence, life experiences.
- Social dimension: links with family, friends, other people, exchange, outings, recreation, respect of worship;
- Cultural dimension: personal improvement and opening to the outside;

The aim of the Unity of life is to support aging people with disability in the essential acts of their daily life respecting their rhythm, intimacy, maintaining their autonomy and social life and developing new skills and capacity.

This support allows to create a special and individualized time:

- For the staff, this may be a way to detect physical or mental abnormality.
- For the client, the support should be a time of revaluation of self-esteem, well-being and autonomy.

In residence Verdi, clients could participate to several activities:

- The pastry workshop takes place once a week (work on the recognition of food and materials, ex. touching food brings a sensory accessibility). This workshop contributes to the concept of sharing and recognition of tastes, flavors and fragrances.
- The board game workshop is a time of gathering the group. This workshop develops links with others, mutual help, sense of competition, exchange and discussion.
- The manual workshop offers short-term activities when there is a specific purpose or occasion (themed decor, gifts ...).
- The soft gym and relaxation to reinforce muscles and balance.
- The lingerie workshop helps residents to understand how an institution's service works.

	- The film workshop during which residents choose a DVD and discuss after the film projection. This workshop gathers all residents, elderly and ageing people with disabilities. This workshop is a relaxing and fosters ties between residents. **Training for professionals:** The team of staff is composed by 3 psychological medical professionals and 2 educators. The staff is trained regularly in order to improve their competence for a better support of clients. For example, the training is based on analyses of concrete cases, on relational approach in case of refusal, aggression, on work on verbal communication, and on study of different types of disability, their evolution with age in order understand better the needs of aging people with disabilities. Also, this training improves the quality of communication with the clients.
DESCRIPTION OF TARGET GROUP	Staff in institutional accommodation for elderly Ageing people with disabilities
MEANS/MEHODES OR TOOLS USED	Several evaluations are done: - Evaluation of quality of life (needs and expectations) of resident with multiple tools to collect and analyze their expectations and needs: o Satisfaction Questionnaire; o during the Social Life Council; o investigations; o informal talks; o direct contact; o links with other professionals;
SKILLS INVOLVED FOR THE CAREGIVERS	- Knowledge of the sectors of elderly and disability - Empathy; -Capacity to listen and to understand;
ATTITUDES INVOLVED FOR THE CAREGIVERS	Staff has to be open minded, to love human being

18. Future connections

NAME OF HOST ORGANISATION/INSTITUTION	IRECOOP VENETO
TITLE OF THE GOOD PRACTICE	**FUTURE CONNECTIONS: Cooperation for building a processes of social inclusion for people with disabilities**
GENERAL OBJECTIVE OF THE GOOD PRACTICE	To strengthen the network of social cooperatives for the promotion of an inclusive culture in social work. To promote inclusive practices of dialogue between the public and private system. To help improve the quality of life of people with disabilities and social workers.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	Future Connections is the first action of the system in the territory of Veneto region implemented by the network of the Federsolidarietà (Regional Federation of Social Cooperatives) and unique of this kind in the whole region. Currently it is livving its third edition
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	Future Connections has started more than 3 years ago as a training project promoted by Federsolidarietà Veneto and Irecoop Veneto to accompany actors of the social Cooperation in a process of development of inclusive practices at the organizational, managerial and socio-relational levels to improve the quality of life of workers, volunteers, people with disabilities and their families throughout the life cycle. Connections 2.0 has allowed the construction and implementation of in-depth courses, discussions and sharing among 40 of Social Cooperatives operating in the disability field. The initiative saw participation of 50 managerial figures, like Presidents and other Managers of Social Cooperatives in a process of analysis of changes of the Italian Social Welfare, of the role of Social Cooperatives regarding the ability to measure the social value that it generates in the territories and for persons. It asked 60 Coordinators of service to track the process indicators that can be used as a reference to build decent living conditions and a system of satisfying relationships with regard to persons who have difficulty in their personal and social autonomy, so that they can feel part of the community where to act, choose, play and recognized their role and identity. The 20 organized workshops have provoked lively participation of managers, coordinators, family members, volunteers and even some people with disabilities. The workshops were also an opportunity to favor the rise of new social inclusion programs, activities inside single cooperatives.
DESCRIPTION OF TARGET GROUP	Presidents, managers and social operators from social cooperatives working in the disability field
MEANS/MEHODES OR TOOLS USED	Classroom trainings, experiential trainings, focus groups, exchange of practices and experiences study visits involvement of volunteers and families.

SKILLS INVOLVED FOR THE CAREGIVERS	
ATTITUDES INVOLVED FOR THE CAREGIVERS	
RESOURCES NEEDED	Funds received through various calls for projects, Resources of single cooperatives made available for the initiative

19. Impact of training

NAME OF HOST ORGANISATION/INSTITUTION	IRECOOP VENETO
TITLE OF THE GOOD PRACTICE	Cooperative SOLIDARIETà Treviso Inclusive impacts on an organization of services as a result of training of new approach to disability.
GENERAL OBJECTIVE OF THE GOOD PRACTICE	Increase the quality of life of people with disabilities employed or residing within structure of the organization according to the social inclusion indicators identified in the study programs in which the organization participated. The dimensions addressed: . person with disabilities according to the size subjectivity and autonomy . Family through the involvement and participation . Operators depending on the size of the training and participation . Territory and social resources in view of the interaction and exchange
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	These are innovative practices that show how training processes and participation in different networks have allowed the organization to grow and deal with changes of approach to disability
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The Cooperative Solidarity was founded in 1982 by the desire of some families to create a reality and moments of sharing, hosting and conviviality for people with social disadvantage from the territory. Over the years the reality has expanded and currently in agreement with the Public Service manages two residential communities and two day occupational education centers and new projects that respond to the challenge of new forms of welfare. This way has gorwn the Village Solidarity which is configured as a courtyard around which there have been developed different experiences and social inclusion activities: - The project "A custom-made house" or an apartment for women in a position of social marginality, - The Housing Community “Together with Us”, - An apartment of co-housing for young people, - housing dedicated to the families, - The Toy Library "La Casa dei Colori" - The Centre of Studies for the Family, - A hostel for tourist accommodation -other.
DESCRIPTION OF TARGET GROUP	• People with disabilities included in the services and from local territory • Family members • Operators • other actors of the area (schools, centers of voluntary services, universities)
MEANS/MEHODES OR TOOLS USED	Participative methodologies ICF
SKILLS INVOLVED FOR THE	Participatory way of doing: switch from delegation to

CAREGIVERS	involvement in decision process
ATTITUDES INVOLVED FOR THE CAREGIVERS	Collaborative and pro-positive
RESOURCES NEEDED	Spaces , Economical resources: 1. Participation in calls for proposals 2. Contributions from the part of users, clients (for example, schools for didactic materials or activities, co-financing of some activities by families, etc)

20. Social inclusion policy in Veneto

NAME OF HOST ORGANISATION/INSTITUTION	IRECOOP VENETO
TITLE OF THE GOOD PRACTICE	NATIONAL OBSERVATORY ON THE CONDITIONS OF THE PERSONS WITH DISABILITIES: SOCIAL INCLUSION OF PERSONS WITH DISABILITIES IN ITALY
GENERAL OBJECTIVE OF THE GOOD PRACTICE	DEVELOPING TRAINING MODULES FOR STAFF ON AGEING AND DISABILITY ISSUES
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	To promote new ways of formal and informal caregivers training and monitoring and evaluation of inclusive educational paths
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The National Observatory has been established by a Law in 2009 and its main functions consists of consulting and technical/scientific support for elaboration of national policies on disabilities with the purpose of evolving and improving information on disability in Italy. The Observatory contributes to the improvement of the effectiveness and adequacy level of policies. In particular, Centre promotes the implementation of the UN Convention on the Rights of Persons with Disabilities and the integration of people with disabilities, collects statistical data on the subject, carries out studies and research. As a Good Practice the Observatory presents data of an international project on the theme "Development of a Web Based Training Program for Careers of Elderly People with Intellectual Disability Achievements". The AGID project has been co-funded by the European Commission and additionally in Austrian fund and it has developed a training platform in e-format on Ageing and Disability issues with the primary aim to provide quality services to aging people with ID.
DESCRIPTION OF TARGET GROUP	- formal and informal caregivers - curriculum developers - practitiones in the field of disabilities; - policy makers
MEANS/METHODES OR TOOLS USED	The Observatory implements: - researches, surveys and collects statistical data; - elaboration of reports and recommendations for policy makers; - organization of seminars, meetings and other events.
SKILLS INVOLVED FOR THE CAREGIVERS	
ATTITUDES INVOLVED FOR THE CAREGIVERS	
RESOURCES NEEDED	
NOTES	

21. Training and innovation

NAME OF HOST ORGANISATION/INSTITUTION	IRECOOP VENETO
TITLE OF THE GOOD PRACTICE	Approaching changes in a Network; methodology of training and development of innovation – Irecoop Veneto / Federsolidarietà Veneto
GENERAL OBJECTIVE OF THE GOOD PRACTICE	To promote a culture of Inclusion among services/organizations for persons with disabilities To support innovation of nonprofit and profit organizations in order to favor Social Inclusion in practices, approaches, policies.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	It is a practice that for the first time brought together various actors (institutional, profit, nonprofit, families and persons with disabilities) around a common thought – to increase Social Inclusion.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	The Convention of UN on the Rights of Persons with Disabilities is requesting various changes from society and as well from those actors working in the related field. In order to make a real difference some singular initiatives are not enough. Changes are often needed in organizational, system level and thus requires larger involvement, sharing- collaboration among diverse actors. Work of a network foresees sharing of a common vision on the reality of reference, the exchange of experiences and expertise as well as the definition of roles and of stakeholders useful to avoid overlapping of interventions. On this basis over the past years Federation of social cooperative and Irecoop Veneto have built synergies with institutional, profit & nonprofit organizations, families and persons with disabilities in order to promote a Inclusion as a driver of cultural and organizational change. It is about the implementation of a process of changes starting from low level aimed at enhancing implicit and explicit responsibilities of the involved actors. Training (especially a continuing VET training) in this experience has been an important stimulus for favoring motivation, positive reciprocal contamination etc.
DESCRIPTION OF TARGET GROUP	Political, technical and operational actors involved in the services for persons with disabilities Social enterprises and voluntary associations Persons with disabilities and their families
MEANS/METHODES OR TOOLS USED	Training activities; Seminars and conferences; Working groups and round tables Exchanges of experiences and practices Study visits Elaboration of common documents, visions, projects…
SKILLS INVOLVED FOR THE CAREGIVERS	Knowledge of procedures, practices, approaches Knowledge of good practices (local, national and international) Implementation, realization of Social inclusion in services, practices Collaboration with other actors

ATTITUDES INVOLVED FOR THE CAREGIVERS	
RESOURCES NEEDED	

22. Attitudes PFA

NAME OF HOST ORGANISATION/INSTITUTION	ESKILSTUNA MUNICIPALITY, DEPARTMENT OF CARE AND SUPPORT TO PEOPLE WITH DISABILITIES
TITLE OF THE GOOD PRACTICE	PFA - Pedagogical attitude and way of work in the care, support and service to people with intellectual disability
GENERAL OBJECTIVE OF THE GOOD PRACTICE	A *craftwork* development idea/model for professional care, support and service to people with intellectual disability [ID]. The model has its theoretical foundation in Aron Antovskys' salutogenic theory, *every person's right to experience sense of coherence (SOC).*
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	PFA has gained a considerable national interest and is more or less implemented in all care, support and services for persons with ID in Eskilstuna municipality. PFA is considered as a new and promising contribution in the practices in intellectual disabilities. More than 700 books have been sold in Sweden.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	In care and support to persons with intellectual disability [ID] theories and models often are sparsely used in the everyday life/care support/service offered to persons with ID. In Eskilstuna municipality, PFA; Pedagogical attitude and way of work in the care, support and service to people with ID has been developed and gained a considerable national interest. PFA is today more or less implemented in all municipal care and support/ services for persons with ID in Eskilstuna. PFA is a result of a five-year collaboration between Eskilstuna municipality; The Department of Care and Support to People with Disabilities and Mälardalen University, School of Health, care and Social Welfare. PFA involves starting from each person's individual skill set and difficulties, and from those pre-conditions, create a better life by focusing on the persons' strengths and at the same time compensate for difficulties. To work with PFA equates a craftsmanship where the goal is individually adjusted support to individuals with ID. To be able to do this, staff members and care support and service givers, need good prior conditions to understand and learn about the individual person with ID. The cornerstones and guidelines to work due PFA are; • Knowledge of cognitive functions. • Knowledge of the individual person with ID. • Knowledge of ID and the meaning of living with ID, e.g. how it affects the person in his / her habitat. • Knowledge and skills to apply adaptations and adjustments in the meaning to compensate for the difficulties (both physical and cognitive) • Knowledge of the organization where PFA is applicable PFA focuses on staffs' changed and adjusted attitude and way of work adapted to the individual's specific abilities and needs. PFA can also be described as a person-centred form of care, support and service where each individual is given the level of care, support and service needed, instead of a general model that will suit all in a group.
MEANS/MEHODES OR TOOLS USED	Staff education in PFA including implementation of PFA.

SKILLS INVOLVED FOR THE CAREGIVERS	A changed attitude and theory based way to develop the craftwork care, support and service to people with ID.
ATTITUDES INVOLVED FOR THE CAREGIVERS	PFA focuses on that staff are to change/adapt and develop their *craftwork* (care, support and service) adapted to the individual's specific resources, skills and difficulties and adjust care, support and services to these specific needs. PFA can also be described as a person-centred form of care, support and service, where each person is given the level of support needed, based on the individual's skills and difficulties, instead of a general model that will suit all in a group. With staffs' increased knowledge about themselves and own cognition, possibilities to understanding persons with ID and / or cognitive difficulties increases. PFA can be seen as an interpretative framework, the content can vary greatly from person to person. Thus, it is no method but a way of thinking. It is about staffs' attitudes and knowledge in adjusting care, support, service, and design and fine-tune surroundings to create conditions for a meaningful life. A life of well-being and learning of unique individuals with different abilities and difficulties. PFA means working from a life perspective, with continuity, to use the person's skills and seek meaningfulness. This in cooperation with parents, families and different groups of staff who support the person with ID in his / her life situation. The implementation of PFA involves adapting the behaviour, an attitude and surroundings based on individual needs, with clarity and respect which often means working differently and perhaps untraditional.
RESOURCES NEEDED	Organizational adaption/acceptance of the PFA idea and theoretical foundation. Recourses and interest in develop a changed idea and attitude in care and support/service to people with intellectual disability. Staffs interest and willingness to change and develop care and support to persons with ID to a craftwork.

23. V.I.P. program

NAME OF HOST ORGANISATION/INSTITUTION	ESKILSTUNA MUNICIPALITY, DEPARTMENT OF CARE AND SUPPORT TO PEOPLE WITH DISABILITIES
TITLE OF THE GOOD PRACTICE	**The V.I.P. program.** V.I.P stands for very important person.
GENERAL OBJECTIVE OF THE GOOD PRACTICE	The V.I.P is a programme to prevent domestic violence agains women and men with intelectual and mental disabilities. The aim and goal of the V.I.P.-program is to minimize the risk for the person with disabilities of exposing her or himself of destructive relationships. To minimize the risk of him or her getting abused by others, or abusing others we work to increase the disabled person's self-esteem. Through reaching more and a better awareness of their own feelings, training their personal boundaries, we can increase the participant's possibilities to make better choices in different situations. By exchanging opinions and experiences in the group, values are challenged and different processes are starting that can lead to a changed behavior. The assumption is that an increased knowledge about feelings, relationships, personal boundaries and violence will lead to a decreased exposure in situations that involves power and control, and also an increase in attention and reporting of violence and abuse.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	There is a shortage in methods and good practices when it comes to working to prevent violence for our target groups of service users, and especially for men. This makes it even more important to highlight. The V.I.P program has given us the experience in working with a prevention of violence program especially produced for our service users with intellectual and psychological disabilities witch is unique. Also we have found a way of making the program attractive for men and a lot of men are applying to each semester. The topic of how we recruit the participants and the conditions we create in the groups is one of our success factors, that we would like to share with you in Sweden. The V.I.P-program is produced and developed by Ewa Fransson Mannelqvist och Kerstin Kristensen and it is based on Ersta vändpunktens och Föreningen Bojens (two compounds) support program that got financed by a project in the Inheritance fund in Sweden. The V.I.P program is based on research and experiences that have been complied in the Swedish Development center Dual Exposed. Their mission was to contribute for the inclusion of woman with disabilities in their ordinary work for safety of women. In 2015 Eskilstuna municipality overtook the license for the V.I.P-program and we are now responsible for the training of new group leaders on a national level. We are responsible for managing, evaluating and developing the V.I.P program and to also be responsible for the national network of V.I.P group leaders. In 2015 the municipal in Eskilstuna also made an agreement to co-produce an evaluation of the program with Mälardalens university, and they are also funding the ongoing evaluation at the moment, we expect the result at the end of the year. The evaluation will be according to program-theory and it will examine if the participating in a V.I.P program will make any long-

	term difference for the participants. The evaluation is also aiming to capture the validity of the program-theory and if these kind of psycho educational efforts is suitable for the target group. We are also interested in viewing how well the group leaders comply with the manual and the matching of the groups. The evaluation will have a gender perspective and we will view the result for both women and men that participate in the V.I.P program.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	V.I.P is a special manual based program for increasing empowerment and Quality of life directly to the participants themselves. The V.I.P program is built on six themes, and they are repeated with recess. The six themes are: The recesses: 1, Introduction 7, Guilt and shame 2, Emotions/feelings 8, Communication 3, Defenses 9, Power and powerlessness 4, Violence 10, Values 5, Risks and choice 11, Boundaries and safety 6, Me as a person 12, Change and closure For example, theme 2 has the message of all emotions and feelings are okay! The recess in number 7 has the message that you are perfect the way you are! Some important conditions in V.I.P is that men and women are in different groups, and there are always two group leaders. The program is manual based and it consists of twelve lessons, every lesson is two hours and we always have coffee. The V.I.P program consist of different exercises where we draw, write, watch film, role play etc. We can adapt the program based on the individual participants. The program is free for the participants. The participants in the V.I.P program are training to have the lead role in their own life.
MEANS/MEHODES OR TOOLS USED	A manual based educational group program for person with intellectual and mental disabilities. We also have training for group leaders. We give several group programs for service users each year and we train group leaders all over Sweden on a regular basis. The topic of recruiting participant for various discussion groups is a known problematic issue that other municipalities are struggling with. When we are marketing the V.I.P program the participants, the service users, are with us and they share their own experiences of the program.
SKILLS INVOLVED FOR THE CAREGIVERS	• Knowledge of domestic violence against people with intellectual and mental disabilities. • Training for beeing a grop leader of the V.I.P • Courage of leading groups, with different group processes • Structured way of leading the group • Being able to make adaptations of the exercises based on the participants abilities (cognitive, intellectual, mental etc.)
ATTITUDES INVOLVED FOR THE CAREGIVERS	The staff needs good knowledge of domestic violence, good knowledge of cognition and disabilities, adapting exercises on an individual basis. They need to be able to think outside the box if participants have a hard time with communication etc.

	They also have to be able to take care of different feelings, emotions and sometimes sadness that emerge within the discussions. They have to be able to keep the rules set by the group. They can use the other group leaders to share good examples and to get inspired in how to execute some of the exercises.
RESOURCES NEEDED	Two group leaders for each group Continously recruting of group leaders Trained group leaders Participants (good recruiting) Support from the board – minicipal – implemetation Educational material Feedback from former group participants Administration of all the groups Evaluation Continously support for the group leaders

24. Pict-o-stat

NAME OF HOST ORGANISATION/INSTITUTION	KARLSTAD KOMMUN
TITLE OF THE GOOD PRACTICE	Customer- and user surveys with Pict-o-stat, adjusted for people with intellectual disabilities or autism.
GENERAL OBJECTIVE OF THE GOOD PRACTICE	To increase the participation in the annual customer- and user survey, for people with intellectual disabilities or autism, by making it easier to answer questions about the help they get from the municipality. To make communication and planning easier for people with intellectual disabilities or autism by using an ipad.
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	Every year we do customer- and user surveys where we ask our customers/users what they think about our work and how they feel about the help and support they get. The main purpose of these surveys is to give information to the municipal citizens, provide basis for the citizens to make choices and provide basis of learning and idea development for the organization. The surveys are based on questions in writing or pictures and sound, depending on the target group. We use a method called Pict-o-stat for those with intellectual disabilities or autism, where we can adjust the difficulty level in the survey with pictures, sound (where a voice reads the question) or movies. Those who answer the Pict-o-stat survey often use an Ipad, but the answering is possible to do on any other smartphone or an ordinary computer as well. Our project to test using Ipad with Pict-o-stat for customer- and user surveys started in 2015. With this way of adjusting the questions, to make it easier for our customers to understand them, made a difference for the response rate. The response rate for people who live in service departments went up from 64 percent to 85 percent. The response rate for people in day centers went from 62 percent to 82 percent. In all our groups the response rate were higher using the Pict-o-stat method than ordinary questionnaires with text only Within Functional Support, some customers use apps in the ipad or iphone to plan and clarify what to do during the day. It may be that you add an image to the store in the app, click on the image and the shopping list will be displayed. Some persons need clearer information about how and what to wash in the laundry room. We use apps that make it easier to cook, clear instructions how to do - the feeling of doing things yourself is a boost to self-esteem!
DESCRIPTION OF TARGET GROUP	People with intellectual disabilities or autism, living in service residence or group residence and/or being in day centers in the municipality of Karlstad.
MEANS/MEHODES OR TOOLS USED	Computer program called Pict-o-stat Ipads, iphones or computers

	Individual adjustments of questionnaires Involving the staff to work with the survey and support the respondents
SKILLS INVOLVED FOR THE CAREGIVERS	Knowledge and understanding about individual customizations.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Positive attitude to new technology.

25. Functional support

NAME OF HOST ORGANISATION/INSTITUTION	FUNCTION SUPPORT IN MUNICIPALITY OF KARLSTAD
TITLE OF THE GOOD PRACTICE	Residence for elderly persons with intellectual disabilities in Karlstad municipality
GENERAL OBJECTIVE OF THE GOOD PRACTICE	
MOTIVATION FOR CHOOSING THIS GOOD PRACTI	To show a way how to meet the problem who comes up with new needs.
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	According to the Act on Special Services for some disabled people, LSS, there are two types of housing for people with disabilities. Group residence for persons with high levels of supervision and care as well as service residence for persons with less need for support. In these homes, people of all ages live in their own apartments with staff support according to individual needs. Over time, people with intellectual disabilities have had an ever-increasing life span, which means that at a service housing it can be difficult to meet the needs that increases when people age. This was a problem we noticed in Karlstad about 5 years ago, a group residence opened where we offered aging people with developmental disabilities and dementia a new residence. A residence and a staff group that would better meet the new needs. As a result of this group residence, we developed a mapping tool on abilities and functions to detect the aging and aging needs of time. In Sweden there is a national web education for staff and relatives of people with dementia. Right now, a similar web education is being developed for staff and relatives of people with disabilities who are aging. That special group residence for elderly persons in Karlstad serves as a reference group in this work.
DESCRIPTION OF TARGET GROUP	Elderly persons with intellectual disabilities. Staff on the field
MEANS/MEHODES OR TOOLS USED	A mapping tool to discover signs of diseases that are related to ageing.
SKILLS INVOLVED FOR THE CAREGIVERS	Knowledge of ageing and personal care.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Awareness of the process of aging and respect for the individual client.
RESOURCES NEEDED	

26. Resource center

NAME OF HOST ORGANISATION/INSTITUTION	KARLSTAD KOMMUN
TITLE OF THE GOOD PRACTICE	Center for resource - a place to meet and get help and support with solutions that will help in the daily life.
GENERAL OBJECTIVE OF THE GOOD PRACTICE	
MOTIVATION FOR CHOOSING THIS GOOD PRACTICE	
SHORT DESCRIPTION OF THE GOOD PRACTICE (+/- 500 WORDS)	In the resource center we have access to most of Karlstad municipality`s preventive functions, related to health and social care. For ex. Showing of aid and tools to increase functions, voluntary center, daily activities for elderly, teams working with dementia and support for relatives. The team are focusing on consultative work and education to staff working with people with dementia. The team working in the dementia area is built with two nurses with special knowledge, one occupational therapist and three assistance nurses. Support to relatives is given to people who supports, helps or cares for someone close who is seriously ill, elderly or has an intellectual disability. The support can be guidance, education or dialogue. In our support to relative team there is four support consultants working.
DESCRIPTION OF TARGET GROUP	Customers and their relatives. Staff on the field.
MEANS/MEHODES OR TOOLS USED	
SKILLS INVOLVED FOR THE CAREGIVERS	Knowledge of the special needs of the elderly and of persons with disabilities.
ATTITUDES INVOLVED FOR THE CAREGIVERS	Open mind for new technology
RESOURCES NEEDED	