Practical Manual

The practical guide for the 'support module for management of care organisations' improving the quality of life for people with disabilities.

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Introduction

Dear trainer, coach or instructor of a recognized care organization in Europe. For you, the official practical manual that belongs to the SMMCO 'Support Module for Management of Care Organizations' trajectory explains. The practical manual has been drawn up by organizations from the Netherlands, Spain and Portugal with the aim of improving the quality of life for people with a disability who need continuous care. The practical manual has been designed by the passion of various people who have experienced beautiful, fun, pleasant but also frustrating aspects in their personal lives while working with people who need care.

After intensive research it turned out that the idea to motivate managers to look at care in a different way was not only in the Netherlands but also in other countries in Europe. By recognizing various challenges and complications in care more people became enthusiastic and saw the need to design a practical module.

It appears, as indicated by the feedback from the participants who received a pilot training. That the extensive teaching material is an interesting addition during standard training courses that are given at MBO, HBO and WO level. There appears to be an added value for the subject matter of this teaching material.

The practical manual is written in a clear and easy way so that it can be used directly within the care organization where you work. The practical manual has all the necessities to give a qualitative training to your colleagues. The practical manual is offered including a lesson planner, powerpoint presentation, exercises and evaluation forms. All documents are written so that you can immediately offer professional and educational training to your employees to optimize the quality of life for your patient, client and/or resident.

We wish you every success in carrying out and delivering the training module and trust that you will experience as many learning elements as we have experienced.

With educational greetings from the international SMMCO team

This practical guide is not intended for commercial purposes as described in the Erasmus+ indicated documentation. If you have positive feedback after the practical guide, we would like to receive it and you can send it to the email address: [*info@smmco.eu*](mailto:info@smmco.eu)

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Introduction Practical Manual

Context module for managers of care organizations

Managers of care organizations are confronted with many problems today.

In recent years, much attention has been paid to a person-centred approach, which means that people who are dependent on care are central. This development is in line with the UN Convention on the Rights of Persons with Disabilities and the European Disability Strategy 2020-2030. These developments are based on a citizen paradigm in which persons with disabilities should be treated and respected as fellow citizens with all civil rights.

Many managers of care organizations provide care services that are not fully in line with this paradigm. Service provision from the citizen paradigm has consequences for the organizational structure, management style, culture and competences of care professionals. They are all connected, one cannot exist without the other. This means that providing self-directed support, for example, can only take place if the structure of the organization makes this possible and if the competences of the care professionals fit in with support-oriented care. The question is not **whether** these changes are necessary. It is a matter of time that these changes have to be implemented. Developments in society will require this.

Another important issue that managers have to deal with is the cultural aspect. This does not only have to do with the style of management, but also with the way people with disabilities are treated, the relationships between care professionals, etc. Nowadays, there is also a growing awareness that employees of organizations must be able to work in a diverse, inclusive and adapted work environment. This also applies to the professional employees in the care sector. It is important to pay attention to this, also because it is important that care professionals keep their jobs, that they do not leave. There is a great demand for care professionals.

It is important for managers to be aware of these developments and to gain knowledge about the steps needed to transform their organization into a support-oriented care organization with professional support staff. All these aspects are covered in the module Support for management of care organizations.

The Reader is background information and covers 14 requirements that should be addressed in the training module

The module is designed to provide insight and develop knowledge about the roots, coherent theory, attitude, instruments and research around Support. In combination with practical cases regarding organisational design, management style, implementation of support services and facilitation of support professionals, the relevant support elements are included in the module.

Criteria

The criteria for participation in the module are based on research showing that the rights of people with disabilities are still neglected or do not have the same opportunities as "non-disabled people" (Basic Human Rights 1989, Vienna Convention).

The basis is performance requirements (PR).

1. Definition and discussion of Support and its essential elements
2. Client-centered therapy (Rogers) and the four dimensions of care (Tronto) in relation to the essential elements of Support.
3. The roots of social exclusion and the mechanism of continued segregation in our society.
4. The role of a support professional.
5. Description and presence of the necessary attitude of the support professional.
6. Description and practical examples of gifts and participation in the community of so-called 'redundant' people based on the achievements of John O'Brien.
7. Description of types of integration (physical, functional, social).
8. Description and discussion of the relationship between the Human Rights Convention and the essential elements of Support.
9. Description of the paradigm shift (development from institutionalization, de-institutionalization to support).
10. Elements of Deinstitutionalization Compared to Elements of Support
11. Description of organizational structures, competencies and management styles.
12. Structure and culture of program-oriented care versus demand-driven care
13. Essential differences between quality of care and quality of life.
14. Description of the necessary conditions for organizational design of Support from the perspective of the customer and the organization.

Lesson Planner

Layout of the lesson planner to use the practice module as successfully as possible within your organization. The practice module consists of eight sessions of two hours. In each session two 'performance criteria' are discussed. In this practice manual you will receive the lesson planner and necessary teaching materials. Separately you can use the power point that fits the practice manual. Each chapter is a session, to ensure the concentration of the participants we recommend to take a short break after every 50 minutes so that the material covered is easily absorbed.

Support module for the management of healthcare organizations

	Time	**Learning objective(s)/problems to be addressed**	**PR**	**Training activities/resources**
1 st session: 1 st hour; 2 nd hour	50 min + 50 min	Introduction of participants and training. Building a shared vision on SDS definition: • Discussion of SDS and its essential elements - individual choice of the citizen in the organization or center; • Client-centered therapy (Rogers) and the four dimensions of care (Tronto) in relation to SDS.	1, 2	
2nd session : 1 st hour; 2 nd hour	50 min + 50 min	The origins of social exclusion and the mechanism of continued segregation in our society. Description of integration types: • Physically; • Functional; • Social.	3, 7	
3rd session : 1 st hour; 2 nd hour	50 min + 50 min	John O'Brien: • Introduction; • The five core values. Relationship between SDO and the international frameworks: • UN Convention on the Rights of Persons with Disabilities; • Sustainable Development Goals (SDG); • Empowerment + self-determination & citizenship + inclusion. Benefits and challenges of SDS.	6, 8	
4th session :	50 min	Description of the paradigm shift: institutionalization,	9, 10	

1 st hour; 2 nd hour	+ 50 min	de-institutionalization, rights-based approach. Comparing elements of deinstitutionalization with elements of SDS.		
5th session : 1 st hour; 2 nd hour	50 min + 50 min	Self-assessment: • Structure and culture of program-oriented care versus demand-oriented care; • Organizational structures, competencies and management styles .	12, 11	
6th session : 1 st hour; 2 nd hour	50 min + 50 min	Self-assessment: • Role of a support professional; • Necessary attitude of supporting professional.	4, 5	
6th session : 1 st hour; 2 nd hour	50 min + 50 min	Self-assessment: • Role of a support professional; • Necessary attitude of supporting professional.	4, 5	
7th session : 1 st hour; 2 nd hour	50 min + 50 min	The necessary conditions for organizational design of support from the perspective of the client and the organization. Essential differences between quality of care and quality of life.	13, 14	
8th	50 min + 50 min	Final presentation of the group. Module evaluation (satisfaction).		

Evaluation

After the module you will be able to:

1. Demonstrate knowledge and insight into person-centered support
2. Facilitate professional caregivers to function as supportive professionals
3. Have knowledge of the necessary organizational structure, culture and management style of a supported organization
4. Knowledge of the required competencies of healthcare professionals to be able to work as support professionals.

Lesson 1 (PR 1,2)

Introduction

During the first lesson of this SMMCO training we will discuss the basic principles of care. How is care defined and can we name various explanations. Then we will discuss theoretical models by Rogers and Tronto. What can we learn from this and more importantly how are we going to apply this in practice.

Performance requirements lesson 1

(PR1) Description and definitions of care, individual choices and awareness of organizational mission statements.

(PR2) Description and discussion of client-centered therapy (Tronto) and the four dimensions of care.

Lesson Plan 1

Specific goals	**Contents**	**Activities**	**Sources**	**Time**
Recognize and understand the different definitions of care and be aware of the organization's mission statement.	Influence of definitions of care for people/elderly people and individual choices	Discuss and provide different definitions of care and discuss the importance of client choice.	PowerPoint presentation Practical cases (practical approach)	50 min
Understand and be able to explain the different theories of Tronto and Rogers.	How do these two different theories change the work ethic?	Present how these four principles benefit the customer. Provide feedback based on a real case	PowerPoint presentation and examples.	50 min

Introduction

In support, the client has the management role. The client must be equipped to actually fulfill this management role.

The support worker is supportive and will create a personal plan based on the direction of the client. The topics that can be discussed are countless.

They are based on the interests and possibilities of the client. An important outcome of support is that the support and guidance is offered, based on the client's own choice, which makes it possible to participate in society. The emphasis is on promoting the possibilities of the client

Support can be seen as a broad form of support and guidance in various areas of life of an individual, usually vulnerable, person who needs this form of support and guidance in order to be able to work in society and to be able to participate in it.

Wiese points to the broad aspect of support and mentions the following three aspects

1. Support is support on request, where the client is in control, supported if necessary by the people around him;
2. Support is a form of support that maintains and promotes the client's self-determination as much as possible.
3. Support must be such a method of support that:
   - a happy life is promoted as much as possible by: being able to make your own choices, having control over your own life, being able to develop yourself and learn through experience, being able to enter into relationships, being able to reach ordinary places in society and being a respected citizen in society.
   - a happy life is limited as little as possible by: your physical and mental condition and health, your living environment, your personal factors, the standards and values of the support staff, living in a residential facility, living in a group and the structure, processes and culture of the organization

The pillar concerns the belief in universal values, thus applicable to every human being. Universal values that have to do with equality, (human) dignity, freedom (of thought), but also happiness, love, respect and justice.

Definitions used in the care sector.

Which definition is most commonly used in the care sector? Using a simple list of words, you can find out whether your organization indicates the importance of the individual and whether there is a description of mission, vision and regulations within the organization.

Use the most common words you encounter in your work environment and discuss with the team the different definitions of the words. What do they mean and is the description the same by all team members? Where do you find different definitions and are they easy to change or agree on?

Demonstration

Many employees do not know the mission, vision or strategy of the organization they work for. If you do not know the goals of the company, it is unlikely that you will provide the requested service to your customer. You may want to consider the following questions. Are you able to create quality care for the person? When discussing the company's policies, someone should be able to develop a pipeline or a roadmap to see what the best approach is within the organization for the person.

Activity

Read the list of opposites based on the questionnaire of Sebrechts (Erasmus University 2007). After filling it in, check whether it matches your partner's. Discuss why you agree or disagree on different definitions.

Lesson 1 Outline

Introduction of participants.

- *Who are you* , *where do you work* , *what is your position* and *why are you participating?*

- *What is your favorite food?*
    - *As an introduction to the participants to show how easily they can decide for themselves in their own situation about an important part of the day*

Introduction of the trainer

- *Who are you*
- Why does your organization choose to offer this training?
- How did the training come about (see ….)

Definition of care

Discuss the definition of care

1. Definition SDS: Self-Directed-Support.
2. Definition: Practice list with equations.
3. Individual choices from your center 'customer-oriented approach.'
4. Goals of your work place.
5. Reputation of your organization.
6. Client-centered therapy, four dimensions (Rogers).
7. Self-Directed Support (Tronto).

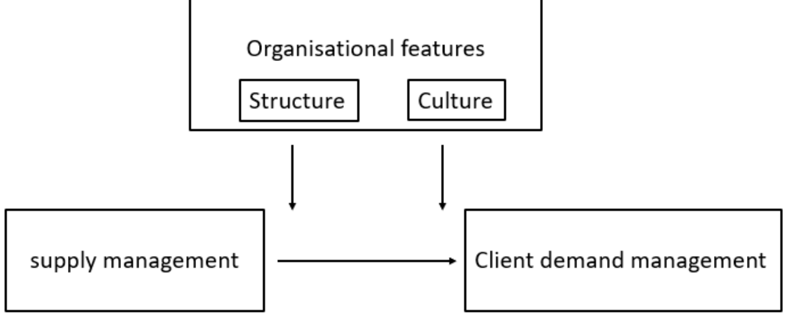
Discuss the performance requirements for sessions 1 & 2

Specific goals	**Contents**	**Activities**	**Resources**
Identify and understand the different definitions of care and present awareness of the organizational mission statement	Influence of definitions of care for people/Elderly and individual choices	Discuss and provide different definitions of care and discuss the importance for the client to have an individual choice.	PowerPoint presentation Practical cases (hands-on approach)
Understand and be able to explain the different theories of Tronto and Rogers.	How do these two different theories change the working ethic?	Present how these four starting points benefit the client. Give feedback based on a real-life case	PowerPoint presentation and examples.

Definition of supply-driven versus demand-driven care

Discuss the definitions with the participants and have the participants determine what situation they think they are in.

Explain what demand-driven and supply-driven means and how this can be achieved within an organization



Source: Sebrechts (1997)

Sebrechts (awareness exercise)

In this exercise, participants receive a sheet (appendix …)
On this exercise sheet 'supply-driven versus demand-driven care' you see two subjects, structure and culture. In the two vertical columns you see two words.
Based on the intrinsic motivation of the participant, a word can be circled. Then circle the word that is common during the own activities. It is not a problem if there are only one or two circles indicated on the sheet.
After filling in the sheet, the participant looks with another participant to see if there are any differences on the sheet. If there are any differences, one can indicate why this was filled in.
One learns how the participant as an individual looks at the organization. And it becomes crazy whether it is possible to adjust aspects within the organization.

Example 1: Sebrechts: Supply-driven versus demand-driven

Structure

	Functional-oriented	of	Competency-oriented
	Centralized	of	Decentralized
	Controled structured	of	Creative/ope structured
	Structured	of	Dynamic

Culture

	Process-oriented	of	Result-oriented
	Functionality-approach	of	Personal-approach
	Organization-specific	of	Professional-specific
	Certainty	of	Uncertainty
	Formal-communication	of	Informall-communication
	Controled environment	of	Flexible environment
	Inequality	of	Equality
	Closed communication	of	Open communication

Based on Supply management and/or demand management Sebregts:
Erasmus University (2007)

Questions asked by the trainer to the participants may include:

- Do you work supply-driven or demand-driven within your organization?
- Do you or your colleagues have the right competence to work in a demand-driven manner?
- Does your organization offer the right services and support to work demand-driven?

Definitions of care (discuss in class)
What does care mean to you?

- What definition of care do you use?
- Is this the same as the organization's definition?

Can your definition apply to all healthcare organizations?

- Explain and discuss

Definitions according to various dictionaries:

- 'What you do for someone who needs help or attention'
- 'The effort, the efforts one makes, the trouble one takes to maintain something or keep it in good condition'.
- 'I will take care of that, I will take care of that'

Individual choices of the patient, client and/or resident (exercise)
Discuss with each other to what extent a patient, client and/or resident has a personal choice for the organization of his or her day?

- Can a client make an individual choice?
- To what extent can your client make an individual choice?
- What support is available for the client to make a choice?

Mission of the organization:
Discuss with the participants whether they know the mission, vision and strategy of the organization?

- Is your own website ever viewed?
- How does the organization profile itself?
- Can you get behind that?
- What reputation is the organization trying to establish?
- Can you meet the requirements stated on the website in your work?

Case Session 1:

Case/statement:
A healthcare organization wants to promote the participation of its clients in society and has started a program for this purpose.
The professional caregivers determined the content of the program and which clients could participate.

- Compare this situation with the elements of support

Rogers & Tronto

Who are these people and what is their importance in your field of work?
To what extent are you familiar with these two people?

Brief introduction to both persons

Carl Rogers (1902-1987) 'The four principles of client centred therapy'	Joan Tronto 'The four dimensions of (good) care
Is best known for devising person-centred theory	Professor University of Minnesota
-Congruence	-Caring About
-The Person-Centered Approach	-Taking Care of
-Empathy	-Care Giving
-Unconditional Positive Regard	-Care Receiving

The Four Principles of 'Client-Centered Therapy' Rogers

1. 'People have a natural tendency to realize individual potential'.
2. The 'Quality of Life' is a personal experience and should not be judged.
3. Is the combination of principles 1 and 2:
4. The individual develops a coherent self-image, meaning:
    1. Based on one's own experience, it creates one's truth about what 'Quality of Life' is.

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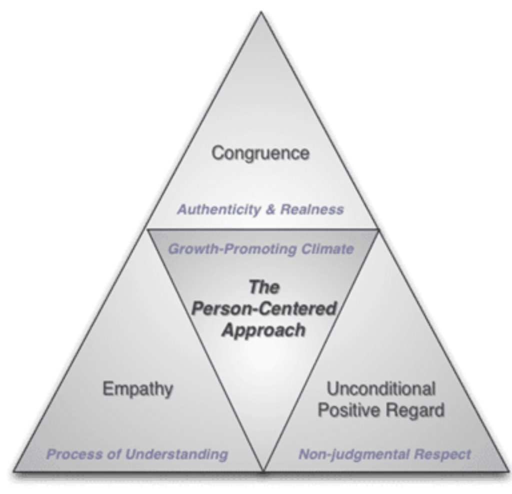
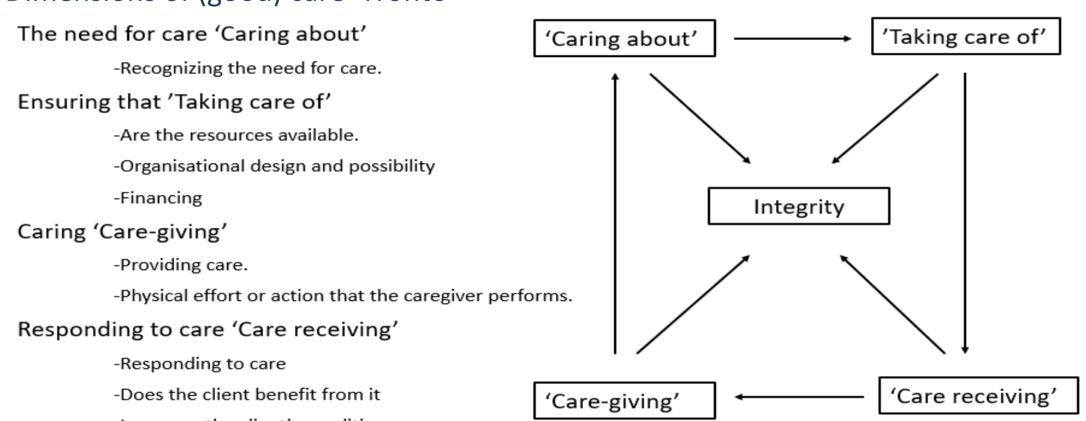


Source: Client-centered therapy model, Rogers

Four Dimensions of (good) care 'Tronto'



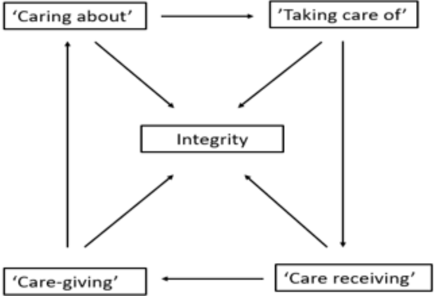
Source: Four dimensions model, Tronto

Activity/exercise 'four dimensions, Tronto'

1. Do all angles have equal interaction when providing care?
2. Is this measured or assumed?
3. Is the budget sufficient for the person who needs care?
4. Is there a possibility to increase the budget?
5. Who provides the care?
6. Is the person providing the care competent enough?
7. Can the care provider do more outside his/her scope?
8. Is it possible to adjust matters to the care provided?
9. Who receives the care?
10. Does the client want more or a different type of care?
11. Has the client been a supporter during communication (someone the client loves)?

Tronto in practice

- With the information gathered, you can return to the framework.
- Check whether all subjects are equally involved in the process of providing care to the client.
- It is possible that some subjects have less or more to offer than other organizations or people.
- Is there a need within the organization to increase certain aspects?



Group assignment

Discuss the question below in your group or with another participant.

- What choice do you make, and why is this choice made?
- What impact does this have on the organization's policy?
- Are there any adjustments that need to be made?

Ask:

In the elderly sector, a care organization has problems with the required number of professional caregivers (many vacancies).
Due to this situation, the management has decided that every care recipient must be in their own room by 9 p.m.

Do you recognize these kinds of decisions?
Can this be addressed?
Is there a long term solution?

Summary Session 1 (Pr 1 & 2)

- What have we learned?
- What do we take home?
- What would be interesting in your organization?
- What could be implemented in your organization?

The client approach (extra theoretical knowledge (Pr 1 & 2).

To consolidate the theory and practical ideas, we use different objectives for a client approach method. The two theories 'Quality of Life' were created by professor Carl Rogers and professor Joan Tronto. Discuss the four principles and whether they are applicable for your organization to use.

Demonstration

In today's work environment, budgets are being cut and fewer staff members are being scheduled to care for clients. It seems almost impossible to follow the findings of Rogers' philosophy. In the previous activity, you noticed that there is a big difference between how you want to provide care (in an ideal world) and what is possible to provide care in the daily care of the client.

Taking into account Rogers' philosophy, you need to prepare how to implement the findings in your daily work responsibilities. Whereby the client's needs are important to create a higher percentage of 'Quality of Life'.

Activity

Show that you can combine the four principles with the three conditions. Take your own work environment as a starting point. Explain how this affects the quality of life for your client.

John O'Brien

John O'Brien mentions 5 core values that are essential to actually give substance to support. These are:

- participate in society;
- being able to relate to others;
- be treated with respect;
- can develop their own potential / contribute to society;
- being able to make your own choices

Role of society

A disability status resulted in a focus not on possibilities, but on limitations. The effect of all this was and still is that people with disabilities experience isolation in many situations and limitations in functioning in daily life. For years, people with disabilities were approached from a "medical" model, and in many situations this is still the case. The medical model assumes that the autonomy of the person with a disability is limited by the limitations. If the medical professionals cannot cure or rehabilitate the person, then he or she is considered as someone who is therefore limited in participating in society. Social exclusion is a consequence of this, the exclusion of people. Furthermore, it also reinforces the dependency of the disabled person.

In economic terms, people with disabilities were less valued because they were not or did not appear to be economically productive. This resulted not only in financial inequality but also in social inequality.

In response to this inequality, the "social model" was developed. Instead of focusing on the disability itself, the social model focuses on society as the cause of the individual's disability problem.

To understand the social model, it is important to distinguish between "disability" and "handicap". Disability is attributed to functional limitations characterized by a physical or mental limitation. Disabilities are linked to the loss of opportunities in society, caused by society's failure to remove the (physical and social) barriers that hinder participation in society.

The social model focuses on breaking down barriers. At European level, the European Parliament stated in the Resolution on the European Disability Strategy post-2020 that all persons with disabilities have equal rights in all areas of life (inclusion and access to an open labour market and education) and have the right to alienating dignity, equal treatment, independent living, autonomy and full participation in society, with their contribution to the social and economic process of the European Union being respected and valued, while more than half of the Member States deny the right to vote to people with mental health problems, health problems or intellectual disabilities.

The focus on breaking down barriers is an important step forward. Looking at what people can do instead of what they cannot, provides perspective. This does not mean that adjustments should not be necessary, on the contrary, they are necessary to facilitate people to participate in society. These developments are important for healthcare organizations. Not everything has to fall on the shoulders of healthcare providers. No longer caring for everything, in addition to care related to the disability, but supporting, facilitating and stimulating inclusion and participation. This also means that a lot has to change in society to make these developments possible.

Self-directed support

There is increasing attention for self-directed support. Self-Directed Support (SDS) is a way of providing support that gives people choice and control over the type of support they receive. It means that people can choose and arrange some or all of their support themselves, rather than it being chosen and arranged by others. It is not the name of a particular type of support service, but a way of ensuring that care and support is better suited to the people who need it.

Self-directed Support is the name for a support system that gives people control over their support and resources:

- Trust - people know their voice is heard
- Control - people shape their support to fit their own lives
- Connections - people develop strong relationships of love and power
- Contribution - people share their gifts and help create a better world (Self-directed Support Network).

The aim of Self-directed Support is to promote independence by providing greater flexibility in the way services are provided to people who qualify for care. Self-directed Support enables people to take greater control over decisions that affect their lives. It aims to support independent living by giving people greater choice, control and flexibility over their own care.

For additional information, please consult the Reader

Lesson 2 (PR 3.7)

Introduction

In the second lesson we discuss the elements of social exclusion, are we aware of this and can we recognize this. During this lesson the theory of three types of exclusion that have been researched is explained. Due to the change in the economic field where inclusion and diversity are increasingly high on the agenda within organizations, we discuss elements how organizations can act. Successfully drawing up an inclusive policy is possible if all stakeholders in the system cooperate. Through practical examples and cases the participant becomes aware of how their own organization deals with minimizing exclusion.

Performance requirements

(PR3) Description and discussion of the origins of social exclusion and the mechanism of continued segregation in our society .

(PR7) Description and discussion of integration types.

Lesson Plan 2

Specific goals	**Contents**	**Activities**	**Sources**
Recognizing and understanding social exclusion and discrimination	The conceptual model: risk factors and characteristics of social exclusion	Presentation of the risk factors and characteristics of social exclusion. Analysis and discussion of practical cases.	PowerPoint presentation Practical cases (1 for disability cases and 1 for old age cases)*
Understand and be able to discuss the relationship between the three types of exclusion.	How do these three types create inclusion between different institutions and between management ideas and customer needs?	Presentation of the three types of exclusion and the advantages and disadvantages of these different disabilities. Discussing the possibilities to take control, depending on the disability.	PowerPoint presentation

Introduction

This lesson discusses how care was started and why there were risks associated with providing care. How was awareness increased and how were adjustments made. What ultimately caused changes and do we recognize this in our personal work environment.

Theoretical framework

In order to recognize exclusion in society, awareness of this complex subject is needed. Social exclusion is seen as a form of discrimination. According to the policy of the European Community, every form of discrimination should be combated. Discrimination on the grounds of disability is important for this lesson. The discussion of various treaties will discuss how legislation has increasingly become decisive for the way in which care should be provided. Article 13 of the

European Community Treaty describes this subject. But the new United Nations Convention on the Rights of Persons with Disabilities is also aimed at discrimination against people with disabilities .

Training setup Lesson 2 session 1

Introduction:

After welcoming the participants, a short evaluation of the previous lesson is an added value to check the recorded learning material with the participants, what has stuck and has this led to a certain action within the organizations.

After the test element, the presentation requirements for this lesson are discussed, these are PR 3 and 7 (outline lesson plan 2).

In this session we discuss the progression from social exclusion to integration. This can be within the organization, society or for example in the private sphere of the resident/client. Name the characteristics of social exclusion to integration (see PP lesson 2)

Discuss the three dominant visions phase of 'Social Exclusion'. This is made visible by using the levels (figure below)

Micro level: people/ live ability (influence)	Meso level: authorities, companies and citizens (minimal influence)	Macro level: government (no influence)
Uncontrollable risk factors *Age* *Gender* *Marital status* *Family composition* *Social background* *Ethnicity*	***Uncontrollable risk factors*** *Inadequate implementation* *Waiting times* *Financial barriers* *Risk selection (by employers, banks, etc.)* *Discrimination* *Stigma*	***Uncontrollable Risk Factors*** *Economic Recession* *Individualization* *Bureaucracy* *Urbanization* *Immigration*

Demonstration.

During the demonstration of this topic you can use news reports in which discrimination occurs. In the enclosed example used, an unsuspecting incident is presented in which people were discriminated against. The organizations are not named for this example and the photos used are not from the organization where the incident took place.

Example: An organization that promotes inclusivity stated in the vacancy that there was room for people with disabilities and that accessibility was not an issue. After the application procedure and a team interview, the participant was invited to the location/workplace.

By public transport, which is generally well organised in the Netherlands but where a person with a disability must calculate more travel time than people without a disability, the participant comes to the final challenge. The stairs to the main entrance. (see photos below)

Activity

Discuss with participants whether there are experiences with 'unwanted' or 'unintended' exclusions and how this has been resolved? Can participants indicate which forms of exclusion they can demonstrate?

The following forms can be shared: 1) Social exclusion, 2) Social cohesion, 3) Financial exclusion/problems, 4) Social participation (work related), 5) Social contacts

Definition article: 'Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and the independence of persons' (see powerpoint lesson 2)

The following affect the article:

1. Non-discriminatoir ;
2. Full and effective participation and integration in society ;
3. Respect for differences and acceptance of persons with disabilities as part of human diversity and humanity ;
4. Equal opportunities ;
5. Accessibility ;
6. Equality between men and women ;
7. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identity .

Additional additions of socio-cultural exclusion that affect the required financial resources are indicated.

Socio-cultural exclusion	Complication or challenge?
-Insufficient social participation -Insufficient participation in formal/informal social networks -Insufficient social support -Insufficient social involvement	-Minimal knowledge of compliance with norms and values -Low work ethic -No voting opportunities (social security abuse) -Minimal chance of reasonable education

Have the participants themselves provide examples where exclusion occurred. Are there solutions and possibilities to prevent exclusion? Or should other stakeholders be approached and is this possible from their position?

When participants work in groups, a dialogue is initiated, which adds more depth to the assignment.

Sample question: Origins of social exclusion.

- For years, people with disabilities were excluded from participating in society. Many residential facilities were located outside the community. Based on new insights from the ministry, a care organization decided to realize a smaller care unit for approximately 150 people with disabilities in the district/neighborhood. All services, including day activities, are provided by the care organization.
  -Can you give your opinion on aspects related to inclusion?
  -Is creating a smaller care center in the community an adequate step or should more be done?

Introduction: Three periods of dominance.

The social exclusion of people with disabilities has a long history and is based on the way people with disabilities were viewed. In the past hundred years, there have been three dominant views (paradigms) on thinking about the causes of disabilities. Three dominant views concern the origin of dealing with people with disabilities.

- Defective paradigm
- Development paradigm
- Official citizen

These paradigms are assigned to various phases of developments that we have experienced throughout history.

Globally, the phases are schematically shown as follows.

Source: Boekhoff, a

Phase 1	Phase 2	Phase 3
Period of institutionalisation	**Period of De-institutionalisation**	**Duration of citizenship**
Defective paradigm (segregation) -biological object (medically colored) -institutionalization -not being able to meet the norms and values of society -establishment far away from society (far from the normal world) -society was protected from the disabled person	Development paradigm -no longer a patient but a person -to exist as normally as possible -ordinary people with special needs and development possibilities -led to de-institutionalization	Normalization paradigm -fighting for attention -Normalization in all facets -specialized facilities within health care and within education. INTEGRATION

Boekhof and Kamp (1994)

Demonstration

Broadening the organizational approach and vision to a client-centered approach. The three phases need to be recognized. Can you demonstrate why some phases are not applicable to your organization?

Activity

Discuss which phase is favorable in your work environment to increase the importance of a customer-oriented approach. What resources are or are not available in your work environment? For this exercise you can also use a SWOT analysis where the group has to fill in where the Strength of a period is, what the weakness of the period is, where there are opportunities in a certain phase and what threats may apply.

The outcome provides a good picture of the phases and possibilities that were and/or are there and do we still see a certain phase within our own organization?

To protect society from people with disabilities, institutions were founded. This way, there could be supervision of 'People who are different'. And if necessary, take direct measures such as locking them up in underground cellars. (see image below, a still existing building of an institution in Vienna, Austria)

A Social Role: Placing an Individual Within an Organization (Institution)

- Narrentum “Fools Tower”(1784)
- Vienna Austria
- 5 floors 28 rooms (139 persons)
- Underground Dungeons

Source: Austria-Forum

Introduction 'Inclusion'

Various organizations indicate that inclusion should be the new magic word/policy? But in which cases is this feasible and is it always feasible? GRIP (2017) indicates that inclusion has come about through a change in circumstances where there are clear differences of exclusion, segregation, integration and the final inclusion.

Demonstration

The model below clearly indicates what the different phases contain and to ensure that inclusion is promoted it is important to discuss whether we are not maintaining the words below the line. Inclusion is namely:

> *'Inclusion is the right to fully participate in society on an equal footing with other citizens, to live an independent life with equal opportunities for choice and with respect for individual choices.'*

Exclusion: Minimal or no participation

In simple language: You cannot/may not participate.

Segregation: Having everything but isolated

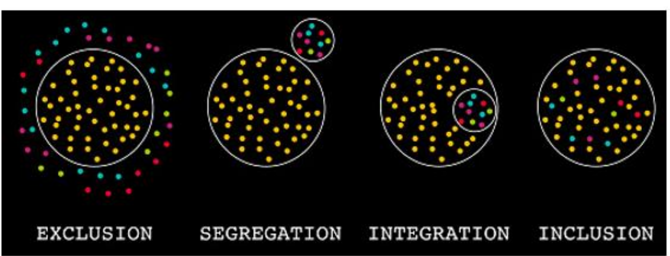
In simple language: A separate environment

Integration: Participating if you can adapt to the rules.

In simple language: You may participate, but you must remove the barriers yourself

Inclusion: 'The right to full participation'

In simple language: You can participate.



Source: I-stock photo

Case

To indicate that one of the three topics still occurs too often, consciously or unconsciously, the following case has been written to make the participants aware of the situation.

The assignment:

A care organization wants to promote the active participation of its clients in society. The management decided to start a small supermarket in a small local community together with their clients and volunteers. They also built houses for clients above the supermarket. Clients who participated in the supermarket were not the people who lived in the houses. The people who lived in the houses went to the day center of the care organization in another village. Clients from other places came to the store to work there.

Discuss and describe in groups when exclusion, segregation and/or integration arose and how the project was suitable to optimize the inclusion of the residents.

Evaluation

After this lesson, a clear definition should have been formed of what care entails and how it is used. Has there been a recognition of the definition that you as an individual or as an organization can stand behind?

Lesson 3 (PR 6.8)

Introduction

In the third lesson, the theory of John and Conny O'Brien is described. These two people have been influential in the way in which the quality of life of people with a disability or handicap can be increased. In a very clear and logical way, it is indicated how a supervisor can deal with his resident and/or client. In the second part, we discuss the UN treaty and the official rights of people with a disability. Where there are references to legislation that we must adhere to in order to promote the quality of life for every individual.

Session performance requirements

(PR6) Description and practical examples of presence and participation in the community of so-called 'redundant' people based on the achievements of John O'Brien .

(PR8) Description and discussion of the relationship between the Human Rights Convention and the essential elements of Support .

Lesson plan

Specific goals	**Contents**	**Activities**	**Sources**	**Time**
Identifying and understanding the five service completions as proposed by John O'Brien	John O'Brien's 5 Service Actions	Presentation of the 5 valued experiences and the 5 service achievements (O'Brien). Analysis and discussion of practical cases.	PowerPoint presentation Practical cases	50 min
Understand and be able to discuss the relationship between the essential elements of Support and two key international strategic frameworks (UN Convention on the Rights of Persons with Disabilities and the 2030 Agenda).	The UN Convention on the Rights of Persons with Disabilities Agenda 2030 The Essential Elements of Support (from Session 1)	Presentation of UNCRPD and the Agenda 2030 Analysis of the rights that SDS seeks to derive from UNCRPD and Agenda 2030 Presentation of different scenarios and discussion on how these rights are addressed or neglected Refer to Commission Notice for information.	PowerPoint presentation	50 min

Introduction to O'Brien's theory

John and Connie O'Brien are thought leaders who have written interesting articles on the challenges faced by people with disabilities and/or impairments. They are two pioneers who strongly believe in person-centered planning.

'Where a person creates his own schedule'.

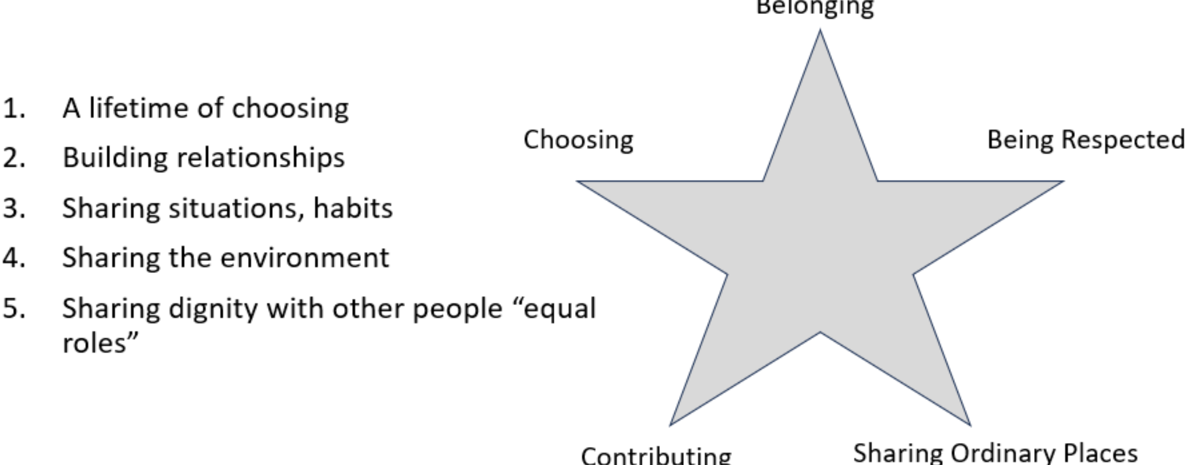
Their vision led to the following model being written, where the value and approach is focused on a 'person-centered approach'. With this model, practical situations, structures and values that lead to segregation instead of inclusion can be tackled and which increases the quality of life.

O'Brien focuses his thinking on the area of 'social role valorization' or 'Social Role Strengthening'.

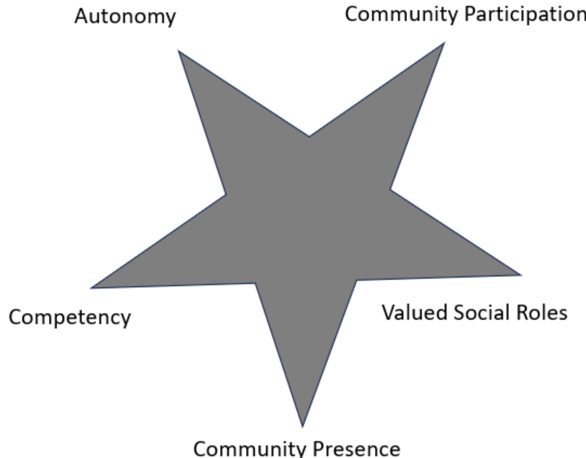
Demonstration

O'Brien has developed two simple stars, each of which differs. The first star indicates five valued experiences for a better life. The second star shows which achievements are needed to achieve a better life. When these actions are consulted, the focus on 'Person-centered care' is increased because someone's personal needs, wishes and preferences are pursued. This is only possible if the care provider makes contact with the person as a human being. The central question is: what does your client need to feel healthy and happy. Joint learning (client-counselor) so that each person can determine their own direction.

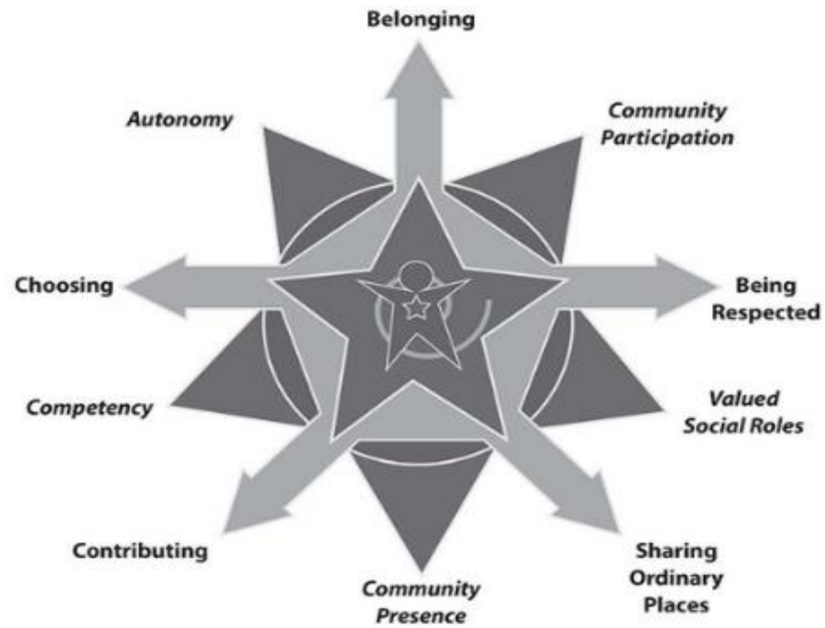
The first star: 'Five valued experiences for a better life'



The second star: 'Five achievements to achieve a better life'



Once all the topics depicted in both stars have been discussed, the care for the individual comes into its own:



Activity

Have each individual write down the stars and describe whether the ten elements have been implemented within their own organization or is a similar model used. If another model is used, does it have the same objective? Can both models be used equally and reinforce each other?

Discuss with the group what influence you have as a manager to implement this model and how you are going to explain this to your employees and residents.

Additional Additions O'Brien

O'Brien's theory is based on 'Social Role Valorisation ' (SRV). SRV is a method to improve the lives of people with a 'low status' in society.

SRV (Social Role Enhancement) applies to people who for whatever reason have been disadvantaged, discriminated against or otherwise condemned to a low status in their society. The following people may fall under this:

- People with low incomes.
- Minority groups: particular racial, ethnic, religious or political movements.
- Any form of physical or mental disability'.
- Elderly people who have few or undesirable skills
- Imprisoned, illegal and/or unwanted immigrants.
- Seriously, chronically or terminally ill
- Different sexual identity or otherwise that violates societal values.

The majority of these groups/classes often receive formal or informal services, offered by: families, schools, hospitals, welfare institutions, etc.

SRV is relevant to any form of human service provision, in the fields of education, rehabilitation, psychology, social work, medicine, prison/corrections, etc. The precursors of the Social Skirt Reinforcement Model originated in Scandinavia (Nirje, 1969). In 1983 Wolf Wolfensberger formulated the term SRV as his successor to the earlier 'Principle of Normalization In Human Services'

The International SRV Association was founded in 2013 to promote educational and leadership development so that vulnerable people can have access to the good things in life.

As an additional addition, O'Brien's video can be used during the lesson.

https://www.youtube.com/watch?v=p5iMTSF938I

Case

In a small village there was no facility for elderly people who needed care. For certain services they had to travel to another city which was not appreciated. The municipality decided to create a service point in the village. So that elderly people no longer had to travel.

Only due to a shortage of staff many volunteers worked. At a later stage it was decided that housing and care should be separate responsibilities.

A housing corporation was given responsibility for the homes and rented them out, to various other people (non-elderly) came to live. The organization responsible for the care services decided that more professionalism was needed and that because of the costs of the professionals, only a limited number of hours could be used of the service point. Nowadays, the entire original concept has disappeared.

What do you think, what went wrong?

Could it have been done differently?

Lesson 3 session 2

Introduction

The SDS Framework is aligned with a vision of international rules and guidelines that address the human rights requirements for all people such as: Dignity, Empowerment, Self-determination, Citizenship, Inclusion and Quality of Life. In this lesson we discuss the influence and design of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006)

Demonstration

To give an idea of what the UN does and implements, it is important to introduce the group of participants to certain statements and test their knowledge. The following questions can be asked to the group.

1. In what year was the Convention for Persons with Disabilities drawn up?
   a. 2006
   b. Of the 186 countries, only 164 signed it directly
2. The European Union has adopted this treaty.
   a. When was this?
3. The Netherlands ratified (formally ratified) this treaty in the year?
   a. June 14, 2016
   b. And was one of the last countries

The short questionnaire provides an insight into the awareness of the UN Convention.

Activity

Discuss with the participants the following statements: The UN Convention on the Rights of Persons with Disabilities is for example an expression of full and effective participation in society. There are different opinions about this.

Which of the opinions do you think is important?

Opinion 1:

Society has a responsibility to remove barriers that prevent participation in the community so that specific disability services are no longer needed.

Opinion 2:

Not in all situations it is possible for people with disabilities to participate, so facilities must remain available.

Opinion 3:

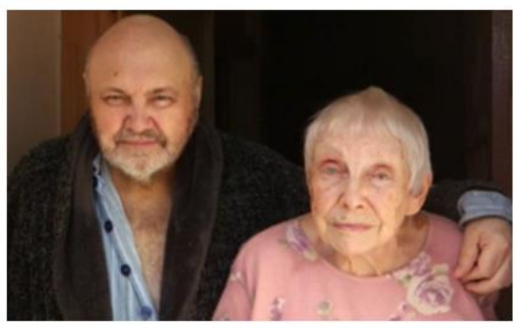
Persons with disabilities have the same rights as non-disabled persons, but because of their disability they need individual support and guidance tailored to enable full participation.

Case Rights Projection

Anna (mother) and Mario (son), Anna has never let go of her son Mario, they still live together.

Anna is 82 years old and has mobility problems, according to the neighbors, to deliver good care for Mario is no longer possible.

Mario's brother John is certain that his mother and brother can still live together. Mario is 43 years old and has a mental disability and cannot live alone but does not want to leave home either. In their view, they enjoy living together



Source: BBC, Carer 93, exhausted looking after disabled son

The complaint from the neighbours and neighbours has been received at your office. It is your task to investigate and resolve this. The UN statements below should be included in the assignment.

- How do you approach this?
- What are you going to do to ensure that their rights are not violated under the UN Convention?

UN Rights for Persons with Disabilities

Below are various articles from the UNCRPD. Research shows that many people working in healthcare are not aware of these articles and that it can therefore be of great added value to share and discuss them with each other.

Article 14 guarantees that people should not be “deprived of their **liberty** ”. And one of the key messages from people with disabilities is that if they do not have control over their own care or support, they cannot live the life they want.

Article 19 guarantees that people should be able to live independently and "choose their place of residence". Despite this, most countries continue to invest in institutional and residential care facilities that effectively deny people the chance of a real **home** that others take for granted.

Article 22 protects people from interference with " **privacy** , family, home or correspondence". However, many people with disabilities lose all of these rights when they are forced into residential care with limited protection of their basic rights.

Article 23 promises to "eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships." Yet, both in legal terms and in the practical organization of services, it is often very difficult for people to establish and maintain **relationships and family life.**

SDG implementation case

The Sustainable Development Goals (SDGs) drawn up by the United Nations in 2015 aim to ensure that all participating countries are focused on implementing the 17 Sustainable Development Goals (SDGs) in their own countries by 2030.

In the area of human rights of persons with disabilities and to ensure that individuals working in various organizations are properly trained, the participant can see whether the goals are described in their own organization.

1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS
THE GLOBAL GOALS For Sustainable Development

Source: . The 17 SDGs NL

Although this is not a disability specific document, "persons with disabilities" or "handicaps" and "persons in vulnerable situations" are specifically mentioned several times (). The 17 main goals clearly indicate where the focus should be while the 169 sub-goals should ensure that they are explained more specifically.

Activity SDGs

Let the participants look at which goals are already accommodated within their own organization. And the next assignment is aimed at making choices of the SDGs that can be implemented in their own organization.

The following SDG goals are relevant for improving the quality of life of people with disabilities.

Objective 4:
The rights to quality education to promote people's opportunities. Lifelong learning for all.
Objective 8:
To promote sustainable and economic growth that provides productive employment for all.

Objective 10:
To strive for zero inequality in order to increase opportunities in social and economic terms.
Objective 11:
Making cities safer, sustainable and accessible for every individual, including affordable transportation.
Objective 17: Increase collaboration between all stakeholders involved in improving the quality of life for people with disabilities.

Additional addition to accompanying document 'Commission Notice' 2024 Brussels (see reader appendix 1)

Lesson 4 (PR 9 and 10)

Introduction

In the fourth lesson we will continue with the paradigm shift that has taken place in the care methodology. In what way have new ideas emerged and has the world started to look at the place of people with a disability within society. The interpretation of certain systems is discussed in this chapter.

Session performance requirements

(PR9) Description of the paradigm shift (development from institutionalization, de-institutionalization to support) .

(PR10) Elements of deinstitutionalization compared to elements of Support.

Lesson plan 4

Specific goals	**Contents**	**Activities**	**Sources**
Understanding the differences between an institutionalization and a deinstitutionalization scenario, and the implications of this paradigm shift	"Threshold evolution": Institutionalization paradigm Deinstitutionalization paradigm Citizenship paradigm	Presentation of "Threshold evolution Develop and discuss scenarios for the 3 paradigms	PowerPoint presentation Example of the same service provided to the same person in the 3 phases: institutionalization, deinstitutionalization, rights-based approach
Understanding and linking elements of deinstitutionalization and the citizenship paradigm to elements of Support	Elements of Support (Session 1)	Comparing elements of deinstitutionalization and citizenship paradigms with elements of support	PowerPoint presentation
	Consolidation and application of previous content in an organizational assessment	Assessment (individual work/group work - if participants come from the same organization): 1: Reflection and recording (template) on the evolution of customer service over time with regard to SDS (long term, past and present). 2: Identification of elements in which each organization is or is not aligned with one or more paradigms (to be presented in the next session)	Template (data integration criteria?)

Theoretical framework

In the evolution of 'caring for' people with a disability. Three thresholds can be described. Regardless of the fact that the first threshold arose by protecting society from people with a disability, this changed in the other two phases to give people with a disability more rights.

The three evolutionary thresholds that have occurred are:

1. Institutionalization paradigm
2. Deinstitutionalization paradigm
3. Citizenship paradigm

First hurdle:
The conceptual shifts that have taken place with people with disabilities have ensured that there has been a social role. First viewed from safety to the community to the rights of people with disabilities where they could move more strongly in the community. The first threshold was very focused on keeping these people out of society.

Second threshold. Because people came to realize that confinement was not an ideal solution, various studies led to change. During the Rosenhan experiment or Thud experiment, it was examined whether the validity of a psychiatric diagnosis was legally valid. The studies ensured that there was an accelerated movement to reform psychiatric institutions and to deinstitutionalize as many (psychiatric) patients as possible. Van Gennep (1997) already indicated that decentralization in care for the disabled, partly due to the 'market forces' at the beginning of this century, resulted in an increase in scale and the 'moving of stones'.

Third threshold: At this threshold the citizenship paradigm is operated. Aristhoteles already indicated in 300 years before Christ that 'it is not realistic to exclude various groups such as: women, slaves, traders and craftsmen who were not official citizens according to the Athenian policy'. Van Gennep (1997) already indicates that 'citizenship paradigm' in the Netherlands plays a prominent role in current thinking with regard to the way in which people with a disability are viewed. We may therefore assume that a continuous positive change is taking place that promotes the possibilities for all people.

Activity lesson 4.1

In the following activity, participants are asked how they fit different ideas into the different paradigms.

All participants are shown the three paradigms: individual theoretical defect paradigm, interaction theoretical development paradigm and social theoretical citizenship paradigm. The participants now receive two sets of cards. The first cards with the subject, such as: Human vision, Status, Caregiver, Place and Social and then the cards that fit the paradigm subjects. It is important that the group looks under which paradigm various contexts belong. The total model can be discussed with the group later.

	Individual theoretical Defect paradigm	Development Phase paradigm	Socio-theoretical Citizenship Paradigm
Human Vision	Person with handicap	Person with possibilities	Person with human rights
Status	Patient	Student	Citizen
Carer	Carer/Docter	Training & Development	To be supported
Place	Institute	Special care	Normal living conditions
Social	Segregation	Normalisation	Inclusion/Integration

Source: Paradigm person with a handicap, Van Gennep 2000

Activity lesson 4.2

The same exercise but slightly different is to share the evolutionary thresholds with the participants and have them place the words under the different paradigms.

The evolution thresholds below are suitable especially for people different organizations that use a completely different organizational philosophy. Participants become aware of the differences and to what extent their own organization innovates to shave off or revise certain elements.

The various phases

Central question	**Institutionalization paradigm**	**Deinstitutionalization paradigm**	**Citizen paradigm**
Who is the person involved?	The patient	The customer	The citizen
What are the "typical" service settings?	An institution	A group home, a social workshop, a special school or classroom	The person's home, a local business, the neighbourhood school
How are the services organized?	The facility	A continuum of options	The unique array that each individual needs
What is the “model” of service delivery?	Domestic/medical	Development / Behaviour	Individual support
What are services called?	Concern	Programs	Support
What is the planning model used?	Individual care plan	Individualized housing plan	Personal future plan
Who controls the planning process?	A professional (often an MD)	The interdisciplinary team	The individual
What is the context of decision-making?	Standards for professional practice	Team Consensus	Personal support groups
What gets the highest priority?	Cleanliness, health and safety	Skills development and behaviour management	Self-determination & relationships
What is the main focus of the intervention?	Control or cure of the condition	Changing behaviour	The environment and attitudes change
What are the quality assurance standards aimed at?	Professional practice and minimum standards of care	Documented programming and goal achievement	Quality of life as experienced by the affected person
How do service providers talk about their work?	Transcending society/community	Aimed at society/community	Within the community/society

Source: Boekhoff and Kamp (1994)

Introduction 'Various ideas'

In various thresholds it is made clear which thoughts various groups have to deal with people with a disability. These thoughts determine very much how and in what way one chooses the right service, treatment or care for the individual. The thresholds are indicated as the following vision: Charity, Medical, Social, Bio-Psychosocial and from the perspective of Rights.

Demonstration

In the accompanying activity we share practical examples in which various visions become clear and where the collaboration comes from. A person with a great sense of charity has a great focus on offering help and relieving the resident and/or client. Medically it becomes clear what needs the resident/client should have based on the known medical data. On a social level we see an involvement of people that goes a step further in the bio-psychosocial level where the emphasis is on holistic well-being. While the Rights purely starts from the legislation and the interests of the person with a disability, when is the person disadvantaged and can we make this known through legislation.

Activity case

In the following two cases we introduce the participants to certain statements that are made. The statements must be placed under the correct column.

Which one fits where:

- Medical
- Charity
- Social and Rights.

A young woman in a wheelchair,

Question 1: 'What a shame, this woman is confined to a wheelchair, she will never be able to marry, have children and take care of her family. Maybe we can find her a nice nursing home where she can live and meet other people'. ? Who made this statement?

Question 2: 'This poor woman, she should go to a doctor and discuss with him or her if there is a therapy that will allow her to walk again, just like everyone else'.

Question 3: 'The community should really build ramps for public buildings so that people like them can participate in social life'.

Question 4: 'She has the right to participate in social activities and the government should remove obstacles that make it difficult for her to interact with other people in society.'

Discuss with the team where you recognize and learn the thresholds of evaluation. Ask the participants what influence this has on the resident, how would this person feel.

Introduction Lesson 4.2

During this session, the role of the support professional will be discussed, the person who is responsible for the individual who needs care at that moment. The professional can be managed by a manager or, for example, from a private situation as an informal caregiver for the person in question. The starting position should be in any situation that the individual is in control. The support professional is the supporter in all areas of life. This can be at home, at work, in free time or whatever.

Activity

But what can we expect from the support professional, what basic attitude is expected and what behavior fits this. From an organization there can be various diploma and level requirements that are monitored, but is this in collaboration with the individual or purely an administrative action that takes up a lot of time?

The list below shows various ways of communication. Each participant receives a list and chooses 8 main elements. After filling it in, the participants look with another participant to see if there are any differences. If there are any differences, the differences are discussed and it is indicated why a person made that choice. During this exercise, awareness comes to the surface and various visions become clear. This is an added value for each participant to see how the individual who needs care is viewed.

Living in society is the starting point of action	**Use normal colloquial language**
Respects everyone's origins and acts accordingly	Has specific communication tools to promote intelligibility and mutual communication
Recognizes the importance of valuable and personal relationships	Uses normal manners
Supports people to shape their relationships and social contacts	Don't patronize
Supports people at home	Shows visible commitment to the person being supported
Promotes the participation of people in the social, recreational, religious and cultural life of society	Has an eye for the individual
Actively enabling people to make their own choices	Trying to put yourself in the shoes of others and in their perception
Provides (visual) aids to clarify choices	Does not impose its own standards and values

Listen to the choices people make	Does not immediately form an opinion about a certain behavior of the person with a disability
Respects the choices people make, even if they go against their own standards and values	Try to understand behavior by looking for backgrounds and reasons
Makes people feel comfortable	Ensures personal integrity
Provides services that meet people's wants and needs	Respects and protects people's privacy
Sees every person as a person with unique possibilities	Connects people
Is aware of personal goals	Offers ways
Uses individual-tailored methodologies to clarify objectives	Has a broad network/uses it professionally
Provides targeted support so that people can develop further and gain a lot of experience	Supports people to shape their own relationships and social contacts
Supports people to further develop themselves in the field of work/activities	Encourages and supports people in contact with parents/family and friends
Respects everyone's origins and acts accordingly	Recognizes the importance of valuable relationships
Respects everyone's lifestyle	Promotes a supportive network in the workplace

Evaluation after the exercise:

Describe together with the other participant whether there are certain elements that often occur in practice and that are not fully or unclearly indicated in the care plan. Indicate in what way the individual will receive better care or a better quality of life? What is required for this and ask yourself whether this is feasible in the situation you are in now.

Introduction Lesson 4.3

In the following exercise we will look at what competencies a manager/coach or other competent person should have to optimize care at another level. (another level could be organizing finances for the purchase of various resources)

Activity

To make the task easier, you can use the headlines below, but you can also have the participants first produce a list themselves and then discuss with each other which elements are a must to receive good guidance while working with the person you are caring for. The competencies that are most often indicated are:

1. create trust: the healthcare worker must feel safe;

2. Listening: checking whether what is said is really meant.

3. Methodical work: the support professional will have to work methodically. He can use methods and techniques that are specifically available for support.

4. motivate and stimulate.

6. promote self-management. The starting point is that the client is in control.

7. results-oriented work.

8. set goals/draw up action plan.

9. evaluate.

Evaluation

People with a (mental) disability are dependent on permanent support and guidance. The supporting professional remains in the picture. This can often involve a long-term relationship with the person with a (mental) disability. The support professional involved will have to maintain his professionalism and give the person with a (mental) disability room to make choices. Because you are dealing with multiple agencies, it remains important that coaching and decisions are coordinated with each other. This can be a long and slow process in which recognized agencies can take over control and the client becomes a number and does not receive the care that the person would like. Partly due to certain reimbursements, according to the law and insurance companies, the demand for care must fit the criteria set by these organizations, which can mean that adequate care is registered differently than initially requested by the individual. A fascinating and interesting process.

Lesson 5 (PR 11 & 12)

Introduction

In lesson five we look at and discuss the various organizations and what goals they have set. Can we assume what kind of organization we work for based on a website or is it important that we get to know the organization better. The various management styles within organizations can also be decisive for the care that will be provided. A very interesting chapter in which strategy, stakeholders and shareholders' interests are examined during the process of offering the best possible care requested by the client.

Session performance requirements

(PR11) Structure and culture of program-oriented care versus demand-driven care .

(PR12) Description of organizational structures, competencies and management styles .

Lesson Plan 5

Specific goals	Contents	Activities	Sources	Time
To be able to analyze the historical development of the organization over time up to the present, from the point of view of the citizens supported.	"Threshold evolution" (session 4): • Institutionalization paradigm • Deinstitutionalization paradigm • Citizenship paradigm Elements of Support (Session 1)	Continuation of the assessment: evolution of customer service over time with regard to SDS (long pass, past and present). Plenary presentation and discussion - evolution of customer service over time with regard to SDS (long term, past and present) (based on the individual/group work completed in the previous session).	Timeline Template	30 min.
Identify key elements of organizational structures, competencies and management styles based on the SDS model	Organizational structures, competencies and management styles	Analysis of the most appropriate organizational structures, competencies and management styles, taking into account the SDS model.	PowerPoint Presentation	20 min.
Be able to evaluate where the organization stands in the field of SDS.	Organizational characterization model	Short presentation of the 7S Mckinsey model: Strategy, Structure, Systems, Skills, People, Style, Shared Values. Individual or small group activity - completing a self-assessment checklist on SDS model based organization - Strategy, Structure, Systems, Skills, Style. Australian Self-Assessment is adapted to care and can be used to find out if client-oriented work is being done. Is added as an	PowerPoint Presentation Video - 7S Mckinsey Model Checklist for Self-Assessment of SDS Model Based Organization	50 min.

		appendix to the reader)		

Introduction to lesson 5.1

Regardless of whether an organization has grown with the developments and the need to provide people with a disability with more rights, an organization always retains its own core value. That core value has arisen from how an organization is set up and has taken shape. A lot of organizational theory is available, but in this session we have chosen to discuss a number of models. The Quinn and Cameron model, the 7's model of Mckinsey model and to be able to evaluate your own organization, the Australian self-assessment tool has been chosen. The special thing about all models is that after this material it is realized where and/or how the own organization moves.

Demonstration

The Quinn and Cameron model (1983), is a model used to understand organizational culture and effectiveness. The model identifies four different culture types that are classified based on two dimensions: the degree of emphasis on internal or external focus (horizontal axis) and the degree of emphasis on flexibility versus control (vertical axis). The four culture types are described as follows:

1. **Family/Clan culture** (internal focus, flexibility): Focused on cooperation, family feeling and development of employees. This culture is characterized by open communication, teamwork and care for the well-being of employees.

2. **Adhocracy culture** (external focus, flexibility): Focused on innovation, creativity and risk-taking. Organizations with an Adhocracy culture encourage experimentation and new ideas to respond quickly to changes in the market.

3. **Market culture** (external focus, control): Focused on results, performance and competition. Organizations with a market culture strive for efficiency and achieving measurable goals.

4. **Hierarchical culture** (internal focus, control): Focused on stability, procedures and control. Organizations with this culture are highly regulated, with clear hierarchies and a focus on efficiency and consistency.

Activity 5.1.1

During the activity with the participants, the model below is shared. This gives a clear and concise picture of the model. Now let the participants indicate on the basis of the model in which type of organizations they themselves work. Once this has been defined by the participants, you can address what the pros and cons are in the organization for optimizing the quality for people with a disability. An important question is, for example: Is an application honored quickly? Over which levels does the guidance for employees go? These questions ensure that the advantages and development points in an organization are clearly mapped out.

FLEXIBILITY

CLAN
- Employee participation in decision making process
- Teamwork
- Empowerment

ADHOCRACY
- Change and Adaptation oriented
- Creativity thinking
- Entrepreneurial behaviours

INTERNAL **EXTERNAL**

FOCUS

HIERARCHY
- Rules and Regulations
- Control improve efficiency
- Internal Efficiency

MARKET
- Goal achievement
- Competition
- Producer and Competitor Roles

STABILITY

Source: Quinn and Cameron (1983)

Activity 5.1.2

To give the group an even stronger picture of the various organizational cultures, you can print out and cut out the eight elements below. The four cultures remain together, but the four descriptions of the organization are cut separately. The participant can now determine for themselves which elements belong to which culture. After that, an evaluation can take place that shows whether these elements fit the organizational culture in question.

Clan-Family culture: good relationships, flexibility in processes, care for staff, customer sensitivity.	Adhocracy: external positioning is central. flexibility and individualization play a major role.	Hierarchical culture: good internal relations need for stability, manageability and clarity.	Market culture: externally focus on relationships. need for manageability and stability.
Friendly work environment; Leaders are mentors Loyalty and tradition High commitment Flexibility Care for staff Teamwork.	Creative work environment Leaders are innovators Experiment and innovate. Leading flexible and individualistic.	Formalistic and structured Leaders are coordinators Formal rules and policy documents Need for stability and manageability.	Results-oriented Competitive Leaders are hunters Reputation and success External positioning Need for stability and manageability.

The next question is which structure, culture, management style fits a supply-oriented organization, a demand-oriented organization or a demand-driven organization. If an organization does see that it

fits the organization but would like to implement a change, an organization coach can guide with the internal process to implement the change.

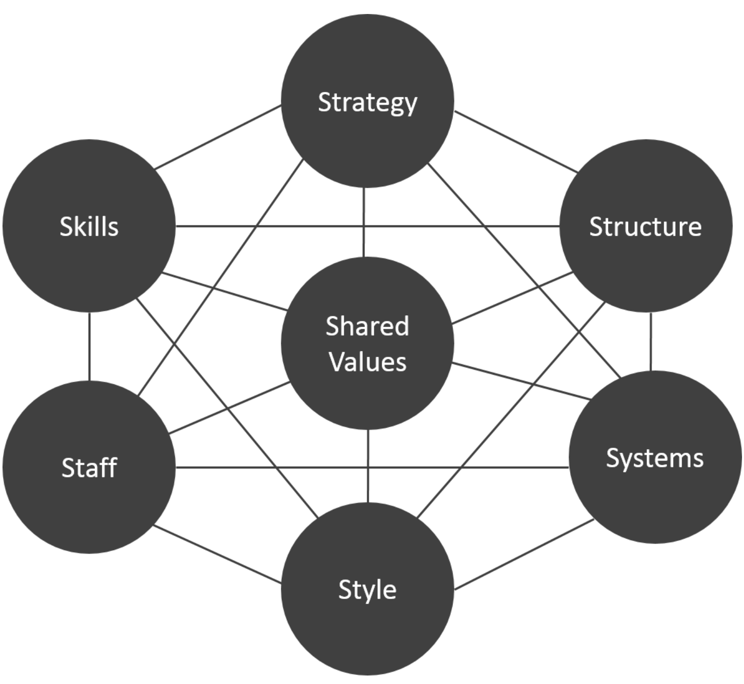
	Supply-oriented organisation	Demand-driven organisation	Demand-oriented organisation
Structure	Bureaucratic Centralistic Monodisciplinary Separate services	Team-based Multidisciplinary Locations Integrated management	Individually focused Independent units Decentralized organization Facilitating management
Culture	Roles/functions Internally focused Top problem with urination	Tasks Team spirit Top-down/ bottom-up Problem solving	Person-centered Innovative Upside-down Problem prevention
Management style	Directive	Participating/coaching	Coaching/involvement
Administration	Standardization Top Budget Management	Location-based budget management Budget per team	Location-based budget management Budget per team
Typology	Professional Bureaucratic	Division culture	Adhocracy culture

Activity 5.1.3:

The McKinsey 7S model (1982) is a management model developed by Tom Peters and Robert Waterman while working for McKinsey & Company. The model helps organizations analyze and improve by connecting seven internal elements. These seven elements are:

1. **Strategy** : The plan by which an organization intends to achieve its goals, taking into account the external environment.
2. **Structure** : The way an organization is structured, including hierarchy, departments, and reporting lines.
3. **Systems** : The processes and procedures that support the day-to-day operation of the organization, such as IT systems and working methods.
4. **Shared Values** : The core values, culture and beliefs that guide the organization and influence employee behavior.
5. **Style** : The leadership and management style used within the organization.
6. **Staff** (Personnel): The people within the organization, their skills, knowledge and capabilities.
7. **Skills** : The specific skills and competencies that exist within the organization and are necessary for success.

The model emphasizes that all these elements are interconnected and that changes in one of the seven areas often have an impact on the others. This makes the 7S model a useful tool for analyzing and implementing strategic changes within organizations. It is often used in restructuring or strategic reorientation. If we want to improve an organization based on the service we provide, this can be an ideal way to implement a new strategy.



Source: Peters (1982)

Introduction Lesson 5. 2

The organizational culture is an important element of the strategy that is maintained and through which the competencies of employees are determined. If there is a certain strategy, then this determines the way of giving and dealing with care to the client/resident. The diagram below shows the change that takes place while maintaining a certain paradigm.

Development paradigm	Citizenship paradigm
The customer	The citizen
A specialized facility	The person's home, the school nearby
Differentiated options	Care needs of each individual
Development/behaviour	Individual support
Programs	Support
Individualized housing plan	Personal plan for the future
The interdisciplinary team	The individual person
Consistency within the team	Personal support groups
Development of skills and behavioural aspects/control	Self-determination and relationships
Behavioural change	Change of environment and attitude
Documented programming and target approach	The quality of life as experienced by the person concerned
Focused on society/community	Within society/community

In order to set up a demand-driven organization, employees need to have different competencies than in a supply-driven organization. According to Akkerboom (et al 2005), for executive employees these are: solution-oriented, anticipating, organizational skills, client orientation, negotiating, flexible and independent. And for managers: imagination / creativity, entrepreneurship, organizational skills, client orientation, directing, enthusiasm / stimulation and result orientation. Examples of personnel instruments that can be used to develop demand-driven competencies in care providers are recruitment and selection, personnel planning, reward and recognition, employee involvement, education and training. Akkerboom (2005) has listed seven 7 competencies for working in a demand-driven support organization as follows.

Conceptual	Operational	Relational	Personal
1: Solution-Oriented	2: Anticipating	4: Client services	6: Flexible
	3: Organisational Skills	5: Negotiating	7: Independency

Activity 5.2.2:

The Australian model (see appendix reader) has been converted from health care and into the reality of this program. The seven characteristics of the Australian model have been formulated as follows to test person-centered organizations. The model has been written so that it can be investigated whether an organization works client-centered.

The seven characteristics are:

1: Comprehensive care delivery

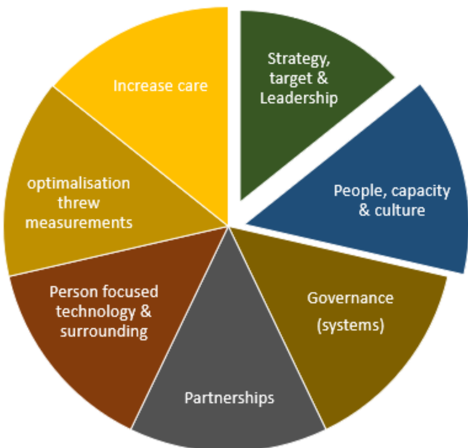
2: Clear purpose, strategy and leadership

3: People, capabilities and a human-centered culture

4: Person-centered governance systems

5: Strong external partnerships 6: Person-centered technology and the built environment

7: Measurement for improvement



Source: The Australian model'2002

1. Comprehensive health care
2. Clear purpose, strategy and leadership
3. People, capabilities and a culture where people are central
4. Person-centered governance systems
5. Strong external partnerships
6. Person-centered technology and the built environment
7. Measurement for improvement

The information below describes all seven characteristics:

Feature 1: Comprehensive care:

- Clients are involved as partners in their care
- Care goals drive clinical decisions and the patient journey
- Diversity and equality are respected and supported
- Transparency is a core element of safety and quality assurance

Characteristic 2: Clear purpose, strategy and leadership:

- The pursuit of exceptional person-centered care is clearly stated in the organization's purpose and strategy
- Good leadership drives exceptional person-centered care, with the support of champions throughout the organization
- A person-centred strategy is brought to the attention of staff and the community, and implemented across the organisation.

Characteristic 3: People, capabilities and a people-centric culture:

- An organizational culture for person-centered care is built and maintained through a systematic long-term approach

- The capabilities of all employees are continuously developed through formal and informal learning
- The organization regularly monitors the satisfaction and well-being of its staff and is committed to this.

Feature 4: Person-centered governance systems:

- Consumers and the community are involved in governance at all levels
- Consumers are trained and supported to make a meaningful contribution
- Organizational structures and care models are designed around the person
- There are clear responsibilities at all levels - from the board to the clinician
- Financial, strategic and operational decisions and processes are person-oriented

Feature 5: Strong external partnerships:

- Care organizations have an extensive network of service partners and relationships
- There is a focus on seamless transitions and coordination of care
- Care organizations operate as leaders in system improvement
- Community volunteers are recognized and supported as critical partners in improving the patient experience

Feature 6: Person-centered technology and built environment:

- Person-centered design principles are applied to the built environment
- Care organizations are pragmatic and innovative when resources are limited
- Technology should improve patient experiences and outcomes, but it should not be used alone

Feature 7: Strong external partnerships:

- There is a culture of learning and continuous improvement
- Measurements can be used to improve outcomes and reflect what patients and communities care about.

Case Lesson 5 .1

In this case, which ties in with PR 11, the participant is expected to define the culture, required competencies and management styles in their own organization. By writing out this exercise and evaluating your data with other people within the organization, you will receive a good picture of how work is done. You can note the following:

Please describe your organization's organizational chart and provide characteristics of your organization with regard to management style, administrative rules/planning.

1. What typology does your organization have and explain why?

2. Self-evaluation and management style: In a residential group, 24-hour care is provided. The clients like to have day care outside the organization. The organization that also organizes day care activities in their institution does not allow participation of clients outside their organization and gives the costs and professionalism that are available within the organization as the reason.
3. What is your opinion about these thoughts?
4. And how are you going to tackle this as a manager?
5. What arguments do you use?

In order to stimulate the development in care, we look at supply-oriented care and demand-driven supported care. Can we state that there is a relationship for the two approaches and does this influence the existing structure of an organization or the culture within the organization. In the model below, Sebregts (2007) indicates that the structure of the services and the culture must be in accordance with the type of care provision.

	Supply-driven care	***Demand-driven supportive care***
Structure	Function-oriented	Competency-based
	From outside to inside	Inside out
	Centralization	Decentralization
	Control	Enterprising
	Structuring	to energize
Culture	Process oriented	Result oriented
	Work-oriented	People-oriented
	Organization	Professional
	Normative	Pragmatic
	Security	Insecurity
	Formal	Informal
	Control	Flexibility
	Homogenization	Individualization
	Stability	Change
	Inequality	Equality
	Closed	Open
	Tight control	Loose control

Source: Sebregts (2007)

Case Lesson 5.2

In the assignment below, groups are formed again. If groups of 4 to 5 people can be formed, an internal and external dialogue will arise, which can provide broadening and deepening regarding this topic. The point is that the participants will discuss how they are going to tackle and solve the dilemma below, what do they see and what actions can be taken.

Exercise 5.2.1:

Research shows that residents/clients have a natural preference and prefer to be supported more often by _the same_ professional.

In concrete terms, this means that one of your employees is often asked to do activities while the other employees are more often expected to do the daily (lesser tasks). You notice that this creates tensions in the group, both between the employees and the residents.
How are you going to solve this dilemma?

Exercise 5.2.2:

The Day Center *'Het mooie pleintje'* offers day care for seniors.
It provides recreational activities, care, meals and companionship in an institutionalized setting.

Participants are transported to the center where they follow a structured program of activities designed to meet their physical and social needs.
The principle of the 'Beautiful Square' does not appeal to the carers and supervisors and they complain that the residents want to do less each time they have been there, which puts the vision of the organisation itself to the test of tackling the problem and promoting self-initiative.
But the dilemma is that the residents always come back enthusiastically.

- How do you deal with this, what advice are you going to give to both management and your direct colleagues?
- Did you consider your choice to address the employees of 'het pleintje'?

Evaluation Lesson 5

During the debriefing of the exercises you get a good picture of the managers and participants how they look at organizations and how the individual looks at this. An organizational culture and structure is very decisive for the behavior of the residents and how they stand in life. Just having nice and friendly people on the floor is not enough. There is a great need to also look at how a person continues to function optimally based on their own input and possibilities. In the PowerPoint lessons various exercises and cases are offered so that the team can work together even more.

Lesson 6 (PR 4 & 5)

Introduction

In lesson six, we look at the important role that the support professional has on an individual level by helping the client to fulfill his or her directorial role. The personality and attitude of the professional are crucial in this. There is often intensive contact between the client and the support professional on a regular basis, in which the work ethic and attitude of the employee are essential. The professional supports the client in various areas of life, such as at home, at work and in free time. Quite a lot is expected of the care professional, such as adopting an attitude that is focused on achieving the client's goals. After all, the client is central. In this chapter, the focus is therefore on the role and attitude of the support professional. The elements are described again with various examples and thorough explanations.

Session performance requirements

(PR4) The role of a support professional .

(PR5) Description and discussion of the necessary attitude of the support professional .

Lesson Plan 6

Specific goals	**Contents**	**Activities**	**Sources**	**Time**
Understand the supportive professional role and necessary attitude according to the SDS model.	Supporting professional in SDS contexts General competencies and attitudes for professional support workers Managing risks and limits	Presentation of the transversal responsibilities and competences of professionals who support people, in different support settings. Group activity - discussion of ethical dilemmas. Recommendations for burnout prevention.	PowerPoint Presentation Dilemmas/cases to be discussed	50 min.
Be able to evaluate where the organization stands in terms of SDS - skills, personnel and shared values	Skills, personnel and shared values – key elements to facilitate the implementation of the SDS model.	Individual or small group activity - completing a self-assessment checklist on SDS model based organization - Skills, Personnel, Shared Values. Analysis and discussion of the results of the self-assessment.	Checklist for Self-Assessment of SDS Model Based Organization	50 min.

Demonstration

The supporting professional plays an essential role in care, where there is a lot of contact with the client. The attitude and work ethics of the professional are important here. During the next activity we will investigate whether the following elements are realistic to ask of other care workers.

Activity 6.1

In the column below, various elements are indicated. This involves discussing in the group whether all elements are realistic for the collaboration to adhere to. There may also be elements that are important but have not yet been written down. Describe new elements and the importance of the specific associated obligations and/or approach.

Living in society is the starting point of action	**Use normal colloquial language**
Respects everyone's origins and acts accordingly	Has specific means of communication to promote intelligibility and mutual communication
Endorses the importance of valuable and personal relationships	Uses normal manners
Supports people to shape their relationships and social contacts	Does not patronize
Supports people at home	Shows visible commitment to the person being supported
Promotes people's participation in the social, recreational, religious and cultural life of society	Has an eye for the individual
Actively enables people to make their own choices	Try to put themselves in the shoes and perceptions of others
Offers (visual) aids to clarify choices	Does not impose own norms and values
Has an eye (and an ear) for the choices people make	Does not immediately form an opinion about a certain behaviour of the person with a disability
Respects the choices people make, even if they go against their own norms and values	Try to understand behaviour by looking for backgrounds and reasons
Promotes that people feel comfortable	Ensures personal integrity
Provides services that meet people's wishes and needs	Respects and safeguards people's privacy
Sees every person as a person with unique possibilities	Brings people into contact with each other
Is aware of personal objectives	Offers manners
Uses methodologies tailored to the person to clarify objectives	Has a broad network/uses it professionally
Provides targeted support so that people can develop further and gain many experiences	Supports people to shape relationships and social contacts themselves
Supports people to develop further in the field of work / activities	Stimulates and supports people in contact with parents / family and friends
Respects everyone's origins and acts accordingly	Endorses the importance of valuable relationships
Respects everyone's lifestyle	Promotes a supportive network in the workplace

The support professional therefore plays a crucial role in the care sector. The support is always offered in the context of promoting the quality of life of the resident/client.

The tasks of the support professional include finding out the wishes of the client, so that the care plan for the resident/client is written, in which the support requested by the client is of great importance. In addition, the professional plays a signaling role, for example in the event of changes in the health or well-being of the client, and directly contacts other stakeholders who are affiliated with the resident/client.

The required competencies for a support professional include creating trust, being a good listener, working methodically, motivating, and promoting self-management in the client. All this while the client remains in control. The support professional can provide very effective guidance in coaching and setting goals, drawing up action plans, and evaluating progress.

For clients with a (mental) disability, long-term support is often necessary. The relationship between the client and the supporting professional is often long-term, and it is essential that the professional maintains his/her professionalism, while the client is given the space to make choices in which reflection on well-being should be optimal.

Activity 6.2

Ask the care professional to record a progress conversation that is held with the Resident/Client. If this is not feasible due to the person's disability, ask a guardian or other involved stakeholder. Before starting the conversation, ensure that there is a clear objective so that the client/resident can easily answer the question. The main thing here is for the resident/client to show how he/she feels in the situation. While making a video recording, it may be easier to see whether a resident/client is content with the question. You can start with very normal questions that occur every day. For example: How did the sandwich making go, did you manage with the groceries and the recipe that you wanted to cook. Feedback should be encouraged as discussed in the example so that progress can be made effectively with the resident (if feasible). Exercises or guidance for a stable future are of course also important.

Example:
Care professional: How did putting on the socks go?
Resident/Client: Good
Care professional: Can you show me how it went and do you mind if I film it?
Resident/Client: That's fine, but I already have my socks on, right?
Care professional: Yes, I see that very well done. But it would be really great if you could show me again how motivated you can get the socks on.
Resident/Client: Well, okay then, but I'll take them off first.
Care professional: Thank you, it's very nice that we can do this together.

In preparation, you can write down various scenarios with other participants so that you can promote your own coaching.
For example:

- What do you do when the resident/client really doesn't feel like it? How do you motivate them?

- What if you don't see any improvement? How do you deal with this without going into a critical mode so that the resident/client gets the idea that it is a punishment imposed from a higher authority and which does not promote the feeling of living one's own life.

Activity 6.3

We have seen that the attitude of the support professional must fit within the citizenship paradigm, where the focus is on supporting the client in making their own choices. The professional must act as a supervisor/coach/confidant who helps the client, without imposing their own standards and values. It is essential that the support professional can put themselves in the client's thoughts and feelings, so that the client can decide for themselves what is good for them. The professional must therefore act in a way that actually enables the client to make choices. This seems easier than it is and we can therefore practice it well with the above activity. Imagery in particular is pleasant to use because the facial expressions of the resident/client can indicate whether the collaboration is experienced as pleasant. Various handles for communication have been placed in the information below.

Development paradigm	Citizenship paradigm
The client	The citizen
A specialized facility	The person's home, the school nearby
Differentiated options	Care needs of each individual
Developing/behavioural	Individual support/support
Programs	Support
Individualized housing plan	Personal plan for the future
The interdisciplinary team	The individual person
Consistency within the team	Personal circles of support
Development of skills and behavioural aspects/control	Self-determination and relationships
Behavioural change	Change of environment and attitude
Documented programming and goal approach	The quality of life as experienced by the person in question
Aimed at society/community	Within society/community

Conclusion Lesson 6

The general aspect is to be open and attentive to others. It does not matter whether it concerns people with a disability or people who are socially isolated for other reasons. The principles of John O'Brien and Baart fit well together. However, behavior of care assistants that is characterized by routines will never contribute to giving a real chance of social integration (presence and participation in society). The attitude of care workers will have to change.

Lesson 7 (PR 13 & 14)

Introduction

The last lesson of the program will discuss the differences between quality of care and quality of life. Can we easily measure the quality that is delivered and should the strategy include 'Key Performance Indicators' as a common thread that the care professional can hold on to. For this session, we assume that the citizen paradigm has been applied correctly and that future-oriented adjustments can be considered to improve the quality of life for people with a disability. At the end of the session, you as a participant are ready to work on your personal assignment. This assignment is suitable for increasing the quality of life for a person with a disability in their own work situation.

Session performance requirements

(PR13) Essential differences between quality of care and quality of life .

(PR14) Description of the necessary conditions of organizational design of Support from the perspective of the customer and the organization.

Lesson Plan 7

Specific goals	**Contents**	**Activities**	**Sources**	**Time**
Understanding the essential differences between quality of care and quality of life	Quality of care Quality of life Quality for whom: key differences between QoL and QoC	Presentation of a QoL model and QoC Plenary discussion of the main differences with a card sorting dynamic (with examples of contrasting features)	Videos with examples of conflicting characteristics between QoC and QoL Cards representing the above opposite characteristics	30 min
Identify and plan the necessary conditions and actions of the Support organizational design from the customer and organizational perspective.	Providing support: the organizational and client perspective The impact on the lives of clients and on the functioning of the organization	Plenary exploration: What are possible future scenarios for SDS? Positive evolution of customer service over time with regard to SDS (now and in the future) Plenary discussion on the consequences and possible challenges	Timeline Template (with Data Integration Criteria)	
	Challenges of SDS Implementation	Demonstrate good practices in overcoming challenges in SDS services	Good practices (service provision, risk management, monitoring, evaluation, ...) KPIs in Self-Directed Support Services	
	Action plan for threshold change	Developing a transformation action plan (with priorities): what kind of changes are needed and how do you	Organizational Action Plan Template (Poster)	

		think they can be achieved? (to be continued independently and presented in the next and final session)		

Demonstration

In order to acknowledge the difference between quality of care and quality of life, we see that De Wael et al describe the following (cited in the article Quality of life, Arduin, December 2007) the following topics are described with a focus on 'The quality of care' and 'The quality of life'.

Focus	***Quality of care***	***Quality of life***
Perspective	The care provider, the organization, the professional	The person himself in his natural network
Interest	Organizational processes must run smoothly: high overhead costs as a result	Desired results for the individual person: lean overhead
Contents	Care systems management: leading to large-scale and groupthink	Individual support and its effects on one's personal life
Typical assessment criteria	Efficiency, cost effectiveness, planning, user satisfaction	Values-based long-term outcomes of inclusion, personal fulfillment and self-determination
Structures	The current care systems simply need to be improved, strict hierarchy	Support should help someone personally, even if that means finding alternative structures. Flat hierarchy in the organization, self-management and coaching

Source: De Waell et all: December 2007

To place the perceptions, behaviors and circumstances that are related to quality of life and that give an indication of someone's well-being in the right context for the individual. It is important to find out whether people with a disability can participate in society. As a care provider you are the supporter of the individual. The right choice can be made by measuring various starting points such as:

- The quality of life of people with disabilities is about as important as that of everyone else.
- Quality of life increases when people participate in decisions about their own lives.
- Quality of life is increased by accepting people and fully integrating them into their own local society.

But how do you do this and what should be considered. Schalock and Verdugo (2002) initiated a basis of eight points that should improve the quality of life for the individual who is the well-being. If it is a 'learning organization' the points can be implemented more easily. The eight points are:

- Emotional well-being: concerns about, for example, being taken for granted, being treated with respect, safety and security.
- Interpersonal relationships: being able to maintain one's own social network.

- Material well-being: refers to the material conditions that protect human dignity, such as privacy, a private space where you can receive visitors.
- Personal development: being given opportunities for personal growth, opportunities to learn and gain experience.
- Physical well-being: being taken seriously in your physical integrity.
- Self-determination: deriving self-respect from the fact that you can make your own choices; making your own decisions.
- Social inclusion: being present and participating in society, belonging.
- Rights: experience that you are entitled to rights.

Source: NHS, UK, 2023

Schalock et al (2002) also indicated that working on quality of life within an organization is important to anchor certain marginal values in the organization. According to them, the following elements are of great importance:

- Client involvement, including: in the development of their individual support plan; deciding for themselves what is important to them.
- Education about important values: inclusion, self-determination, personal development.
- Individual support: person-centred; dialogue-based; flexible; proactive; based on measuring support needs and measuring support outcomes.

The quality of care or quality of life should be linked to each other, but well-functioning processes do ensure an increase in the 'Quality of life' for the individual.

Source: Care in Canada 2021

Because these actions also include various processes, it should be clear. The outstanding processes of elements are indicated.

1. Leadership: Build a shared vision, encourage training and feedback, promote inclusion, and emphasize the importance of measuring support outcomes.
2. Learning teams: self-managing teams, focused on the challenge of new goals, focused on knowledge acquisition.
3. Evidence-based working, which means: using the results of support in organizational change and improvement; thinking from right to left. The focus should be on the outcomes/results of support instead of on input; on goals instead of rules.
4. Self-assessment: as a basis for organizational change/improvement.

Schalock, Gardner and Breadly show that three main indicators can be distinguished between the mentioned domains of Independence: personal development; self-determination. Social participation: interpersonal relations; social integration; rights. And Well-being: emotional well-being; physical well-being; material well-being

Schematically this is shown as follows

Quality of life factor	**Domain**	**Indicators**
Independence	Personal development Self-determination	Education, personal competence, skills Autonomy, personal control, personal goals and values, choices
Social participation	Interpersonal relationships Social integration	Interactions, relationships/friendships and support (emotional, physical, feedback) Integration and participation in society, roles in society, social support/support

	Rights	Human rights (respect, dignity, equality) and legal rights (citizenship, access, fair treatment)
Well-being	Emotional well-being Physical well-being Material well-being	Contentment, self-image, freedom from stress Health, daily activities and leisure time Financial status, employment and housing

Source: Shallock & Verduco (2002)

Case lesson 7.1

In the following case, the participant can make an analysis of the organization where she/he works, in which a comparison can be made with the aspects that are relevant for the quality of care and quality of life. The participant can ask themselves the following questions.

1. Where does your organization stand in this?
2. Are there any changes needed related to the current situation and if so:
3. Why and how do you think these can be achieved?

If the questions can then be evaluated with participants from another organization, it can be clearly seen how various healthcare organizations deal with this element. The following questions can be asked during the evaluation to both participants:

1. In your opinion, is your organization a supportive organization, or do you think no changes are necessary?
2. What do you think is missing and how should that change?
3. If you think your organization is a supportive organization, can you describe what the characteristics are?
4. Do you feel that your organization does not possess either of these elements, what would you like to adopt in the near future?

Case lesson 7.2

In the next case we will go a bit further and use the data from the previous case. This is to generate a necessary trigger which necessary conditions of a supporting organization are important from a client perspective and organizational perspective. Fill in the following questions and discuss this afterwards in small groups:

- In your opinion, is your organization a supportive organization?

If you think no changes are needed.

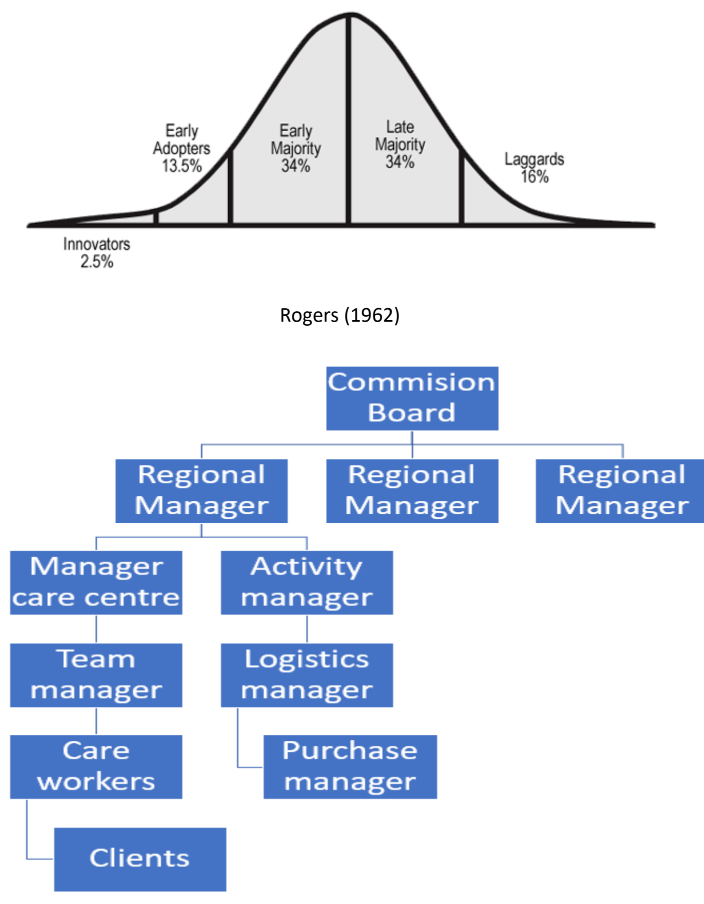
- What do you think is missing and how should that change?

If you think your organization is a supportive organization, can you describe what its characteristics are?

- If you have a different opinion, please explain it.

Demonstration Lesson 7.3

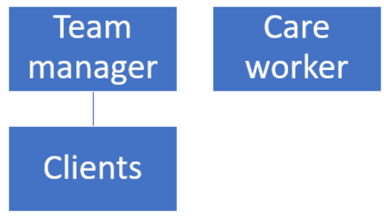
The last topic before the participants analyze their own organization is the necessary conditions that must ensure that a supporting organization looks at the organization from the client's perspective. What does the organization look like hierarchically and is it clear for the resident/client to influence the quality of life for themselves. Care institutions and services for people with an intellectual disability are often already based on an organizational form of supply-oriented care. The care structure then most likely has a number of hierarchical layers. Regardless of the open communication structure of a care institution and clear regulations, it is understandable that a resident/client may have the feeling of not being heard. The hierarchy below shows the different levels. During various training courses it has become apparent that there are many enterprising people who have chosen to run a small one (often a house) with a minimum number of residents in order to be able to guide the individual more quickly, precisely because of the many layers. It is not demonstrated that a large organization should work better or more optimally, it is indicated over how many layers certain agreements must run before a decision can be made. Entrepreneurs who choose to start their own establishment often belong to the first group of 'Innovators' in the innovation and adoption model (Rogers, 1962). These are the inventors who want to be flexible in order to give the resident/client as much attention as possible and to improve the quality of life, you could say to deliver a 'better price quality' to their customers.



Rogers (1962)

Hierarchical organizational model (willemse 2023).

In the following model there is little to no accountability to the organization based on a franchise model. The entrepreneur, often working himself, has direct access to the resident/client with the team and can therefore improve the quality of life more quickly and effectively in collaboration with a small group of stakeholders including: The resident/client, parents or guardian, team of employees, financial institutions (reimbursements)



Flat organizational model (willemse 2023).

Case 7. 3

Describe the organization where you work and indicate how the level of influence in the organization works. Draw an organization chart (Organogram) and describe the functions, competencies and responsibilities. Indicate the advantages and disadvantages of the organization where you work. Describe what is in your power to make adjustments to increase the quality of life for the resident/client.

Lesson 8

Introduction

The last lesson is used to set up a presentation that the participants have to make themselves. In the presentation, the participants should examine the entire organization and investigate which of the learned modules can contribute to optimizing the quality of life. Due to the research for the presentation, there should be the possibility for the participant that the presentation is not immediately classified after the last week. It should be taken into account that the amount of research as well as the scheduling of interviews will take time.

The final presentations should be made in the way the organization presents itself to the outside world and the correct documentation or corporate image should be used. By using the various theoretical models, the participants can clearly indicate in which area the organization can work towards optimization or improvement of possible processes.

Session performance requirements

All performance requirements are used for this pp.

1. *Definition and discussion of Support and its essential elements*
2. *Client-centered therapy (Rogers) and the four dimensions of care (Tronto) in relation to the essential elements of Support.*
3. *The roots of social exclusion and the mechanism of continued segregation in our society.*
4. *The role of a support professional.*
5. *Description and presence of the necessary attitude of the support professional.*
6. *Description and practical examples of gifts and participation in the community of so-called 'redundant' people based on the achievements of John O'Brien.*
7. *Description of types of integration (physical, functional, social).*
8. *Description and discussion of the relationship between the Human Rights Convention and the essential elements of Support.*
9. *Description of the paradigm shift (development from institutionalization, de-institutionalization to support).*
10. *Elements of Deinstitutionalization Compared to Elements of Support*
11. *Description of organizational structures, competencies and management styles.*
12. *Structure and culture of program-oriented care versus demand-driven care*
13. *Essential differences between quality of care and quality of life.*
14. *Description of the necessary conditions for organizational design of Support from the perspective of the customer and the organization.*

Glossary

An extensive glossary of the entire course can be found in the reader.

Citizenship
"(...) status [that] gives individuals and groups the right and opportunity to participate fully in society (...)"

Dignity
"The dignity of the human person is not only a fundamental right in itself, but constitutes the very basis of fundamental rights. (...) It must therefore be respected even when a right is restricted"

Empowerment
“It is the process that enables people to take more control over their lives, to take control over the factors and decisions that shape their lives, to increase their skills and qualities and to build capacities to gain access, partners, networks, a voice, to take control”

Intake
"(...) the process of improving the conditions for participation in society, particularly for disadvantaged people, through improving opportunities, access to resources, participation and respect for rights".

Older person/ individual/ adult
“Older person/individual/adult” are terms that are preferred over “terms such as “senior”, “elderly person” and “elderly person” (...) because they are “different””.

Quality of life (in all stages of life)
"(...) an individual's perception of his position in life in the context of the culture and value systems in which he lives and in relation to his goals, expectations, norms and concerns".

Self-determination
The "free choice of one's own actions or states without external coercion".

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