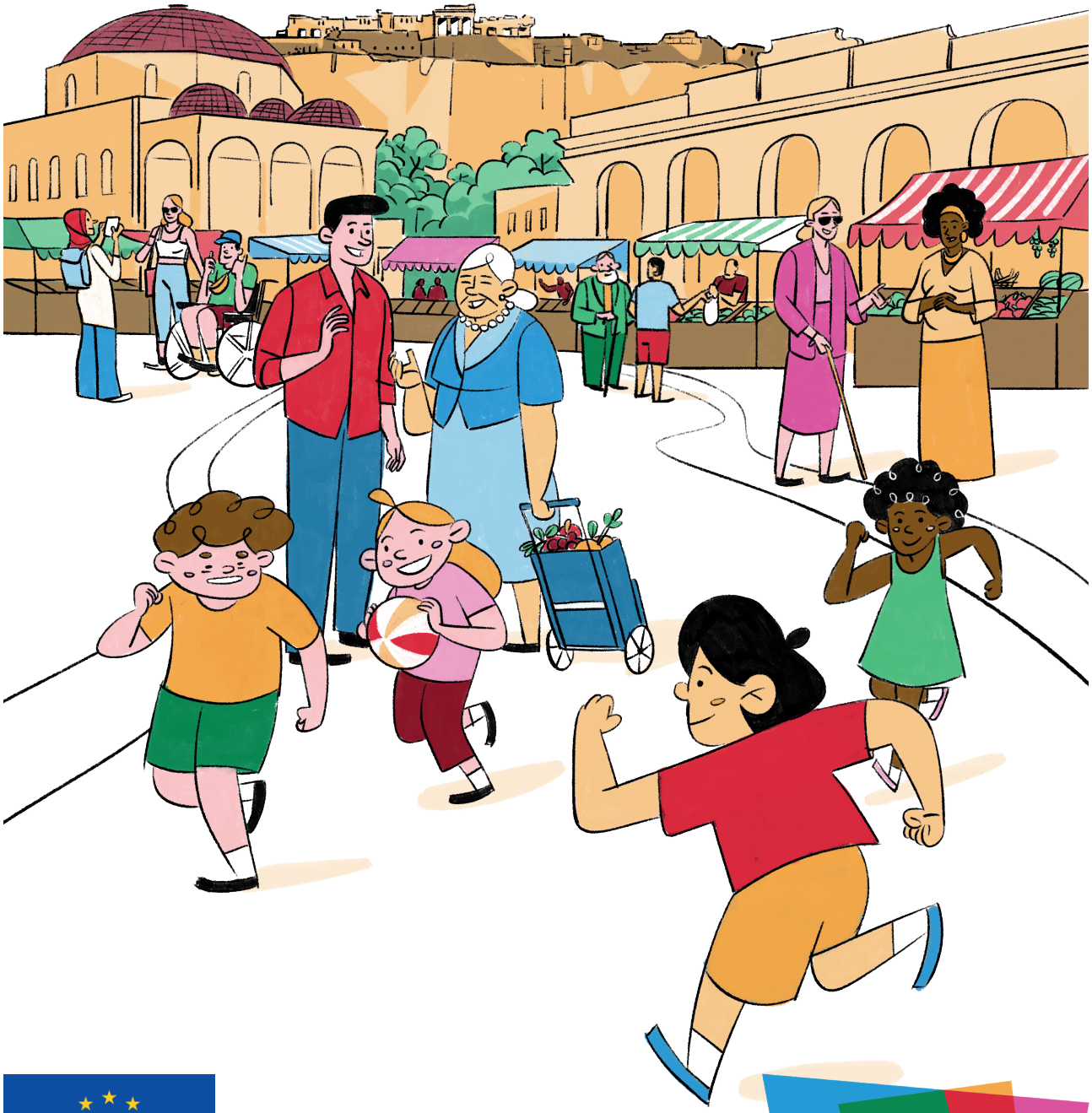
National DI training programme

Technical support on the deinstitutionalisation process in Greece



European Association of Service providers for Persons with Disabilities

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Technical support on the deinstitutionalisation process in Greece Grant Agreement: SRSS/S2019/02
Deliverable 22 (as per the Workplan) under Component 3, Output 3.2 Activity 3.2.1 “Develop a national training programme on DI”

ACKNOWLEDGEMENTS

The European Association of Service providers for Persons with Disabilities (EASPD) would like to thank Vasilis Kasimatis and Constantina Kintoni for authoring this report.

This publication was carried out with funding by the European Union via the Structural Reform Support Programme and in co-operation with the European Commission’s Directorate-General for Structural Reform Support.
The information contained in this publication does not necessarily reflect the official position of the European Commission.

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List of abbreviations

DI
Deinstitutionalisation

EASPD
European Association of Service providers for Persons with Disabilities

ECI
Early Childhood Intervention

ICH
Institute of Child Health

MoLSA
Ministry of Labour and Social Affairs

MIA
Ministry of Interior Affairs

MoEd
Ministry of Education

MoH
Ministry of Health

MoJ
Ministry of Justice

NCDP
National Confederation of Disabled Persons

NGO
Non-governmental Organisation

UN CRC
United Nations Convention on the Rights of the Child

UN CRPD
United Nations Convention on the Rights of Persons with Disabilities

1. Introduction

In the past few years, the Greek Authorities have shown a strong commitment to strengthen the current care and protection system and create the ground for broader reform in the way we support vulnerable children and people in need, in institutions or at risk of institutionalisation. They have emphasised the importance of coordination between existing entities in the welfare, health and education sectors to strengthen preventative services and introduce quality community-based care. They have equally highlighted the need to enhance the social service workforce, improve management systems and ensure financing for new community-based services.

In 2019, the Greek government asked for support from the European Commission for a reform on deinstitutionalisation (DI). The Commission Structural Reform Support Service analysed and approved the request, which resulted in the development of the Technical Support on the Deinstitutionalisation Process in Greece project, implemented in collaboration with the European Association of Service Providers for Persons with Disabilities (EASPD). The project has the purpose of supporting the Greek government in completing the DI national Strategy, a Roadmap and an Action Plan, that lay the basis for the implementation of the DI process; defining and implementing processes and methodologies to run and manage DI; developing communication and outreach strategy and materials; and developing and providing training programmes to support the DI process. The DI Strategy and key deliverables of the project were developed in consultation with stakeholders, civil society, and persons with support needs. This document is developed within this framework and aims to give advice on the development of a national DI training programme, identifying major stakeholders, their role in DI and areas for training.

To provide more extensive participation of the general public in this reform, the MoLSA, supported by non-state actors, has launched a campaign on alternative care. This campaign aims to change social norms concerning society's understanding of persons who draw on support and children who need alternative care forms. As a result, local authorities, Social Welfare Centres, and some small to medium private providers of care may wish to begin undertaking the reform of the residential institution system to community-based care. They understand they need to build capacity and further develop support procedures in the community, to ensure gate-keeping systems and help children and people currently in institutions transition to community-based care. Even though deeply committed, they might feel inadequately equipped to use new tools and practices to undertake a major reform at a regional or national level.

An effective training program with human rights at the core, followed by targeted training to address the specific training needs for different groups of professionals, is an essential tool for change. Training key staff involved in the DI process is a thread of activity that must run throughout the process. It needs careful planning and a clear understanding of the full range of stakeholders affected by or who can influence the DI process. Therefore, drafting a national DI training programme comes after a series of steps. First, the design and delivery of trainings on DI for the social workforce and management of the Social Welfare Centres. After the end of these trainings, participants were asked to complete evaluation forms that were used to draft a training needs analysis only for the social care workforce. This document will refer to the social care workforce but will instead focus on the training needs of other sectors that are involved in DI. A focus group discussion was organised involving different stakeholders and was followed by semi-structured interviews with participants, staff members, and policymakers. This process has led to developing a national DI training programme that will hopefully inspire targeted training programmes to support the reform.

The National DI training program aims to contribute to higher quality care and attitude shift in supporting children, persons with disabilities and elderly persons. This document is not a manual and does not constitute a comprehensive training tool on the DI process. It rather aims at stating the ground on which various stakeholders can develop further training programs in the field of DI.

It is therefore designed to:

- identify the groups of care professionals and stakeholders who need to be trained to train others on critical issues when implementing DI in practice;
- list some of the areas on which they should be trained to complete this reform successfully and tackle the challenges that often arise in alternative care. Indications of further resources are included in footnotes underpinning each aspect of the DI training process;
- contribute to organising a training course intended to provide participants with the information, motivation and strategies that they can use to carry DI values, principles and practices into their daily work. Support them to develop further, design and manage a DI training program in their respective work areas. For this reason, we have included in this document a practical guide to general training. A how-to run training sessions handbook including a program outline.

This document is intended as a basis for the development of targeted training programs initially in community-based social services and institutions that carry out care professionals' training. However, we hope that parts of this document can inspire educational curricula in higher education structures and University departments for care professionals. We also hope that it will inform all care professionals with responsibilities for children and people who draw on support to live in the community.

2. Methodology

This document results from various research methodologies, including literature review, questionnaires, one focus group discussion followed up by semi-structured interviews. The technical assistance to deinstitutionalisation in Greece project undertook the development of a series of research documents and educational activities in the context of technical assistance to the MoLSA. The National Strategy, Action Plan and Roadmap for DI represented the policy component, and other documents were drafted to propose methodologies and support procedures for DI. The literature review includes all these documents and national organisations' reports, and other scientific studies.

As mentioned, in the framework of the project EASPD organised and delivered trainings on DI to managers and executives of Centres of Social Welfare, senior officers at the MoLSA and the Local Government and other stakeholders. Based on the experience and insights gathered during and after the training, we developed a training needs analysis outlining the strengths and weaknesses of the social care workforce in Greece. In order to move from the social care sector to other key sectors involved in DI, a focus group was organized involving professionals and stakeholders of various agencies and follow-up semi-structured interviews with some of the participants and key informants (such as policymakers, caregivers, parents, and service users). Their aim was to provide an overview of the range of professionals that need to be trained to deliver community-based care and improve specific life-areas for service users. Based on the knowledge and experience of participants, we gathered information that supported the analysis of research findings in the rest of the deliverables. Hopefully, this allowed us to combine theory and practice in this National DI Training Programme.

3. Preparing for a National DI training program

3.1 Prospective participants

The professionals involved in the DI process are primarily but not exclusively working in community-based social services and institutions and those who will be employed to support the new community-based system of care. Nevertheless, support procedures in the community involve a range of professionals and stakeholders in various sectors, as well as families and community members. To further elaborate on this issue and identify potential trainees, we organised a focus group discussion and semi-structured follow-up interviews with policy-makers, professionals, trade unions and parents.

Most of the participants highlighted the chronic structural weaknesses of overstretched and understaffed services that would undermine the effectiveness of small-scale training programs and pose challenges on planning a National DI training program. However, they helped us identified the following target groups of trainees: State officers and managers in the national government (MoLSA, MoEd, MoH, MoJ, MoIA) as well state officers at regional and local governments;

- Managers, professionals (social workers, psychologists, speech and language therapists, occupational therapists) and practitioners (caregivers and support staff) in care units (those that will be redeployed from the institutions and personnel that will be recruited);
- Informal caregivers for elderly persons who are supported at home;
- Prospective foster carers and adoptive parents;
- Family members who will be reunited with their children/relatives during the DI process should also have access to training programmes aimed at improving the quality of their caregiving;
- Social care workforce in community-based care;
- Professionals in the juvenile system (prosecutors, judicial officers, juvenile probation officers);
- Community members;
- Health professionals (medical and nursing staff, midwives and professionals in maternity clinics);
- Educational staff members;
- Public benefit foundations, donors;
- Journalists, opinion makers, influencers;
- Volunteers.

3.2 Starting line

The improvement and cross-sectoral management of existing community-based social services and the development of new services will need trained personnel to guide change. Therefore, educational programmes will focus on the social care workforce development, and small-scale targeted training programmes will be developed for the range of stakeholders mentioned above. For example, training for public benefit foundations and donors should be dense one-shot sessions focusing on the poor outcomes institutions deliver, the role of donors in influencing change and evidence-based on investing in alternative forms of care. Training for caregivers will be significantly more intensive and will involve them in general training for DI and targeted training focused on addressing the needs of the people they serve.

The National DI training programme should equip social care professionals and practitioners with sufficient knowledge to design and manage a DI programme in their community or institution. Professionals and practitioners in social care will need to feel adequately supported and supervised to build the confidence required to deliver new working methods of care, facilitate and coordinate access to required services.

The most critical part of training begins before even planning for reform of such scale and complexity. Training for community-based care starts in the Institutes of Vocational Training (IEK) and University departments that educate social care practitioners, professionals and executives who will serve people that draw on support to live in the community. This is highlighted in the literature and in semi-structured interviews and focus group discussion we held. Close cooperation with university departments (such as departments of social work, nursing, midwifery etc.) could help them design and update their curricula so that their graduate students are better equipped to work in community-based support. For example, modules on the social, economic and legal context of community-based care, housing and developing sustainable communities, leadership and management in supported housing and service delivery, practical communication skills, and managing challenging behaviours could help graduates who wish to work in social care deliver better services. The Greek qualified and skilful graduates who have already followed work-based courses that combine social inclusion theory with practice in alternative forms of care will help accelerate the reform process and ensure the quality of care in new services.
Training for the workforce that will be redeployed from the institutions to the new services and other personnel that will be recruited starts at the beginning of any DI program and can only be an ongoing process. One-off training sessions for attitude shift can increase knowledge, but they do not tend to be effective in terms of changing long-term behaviours. As new services will be developed, lessons will be leant, and those will need to be included in the training.

3.3 A national DI training and advisory team

Comprehensive DI training programmes including all elements of the DI reform are still not widespread. A few private or non-for-profit international organisations offer all-encompassing generic training on the steps involved in the process. However, tailor-made, targeted programmes that go into depth on how to apply each step in national contexts (which are mostly needed) are harder to build without local organisations, federations, and professionals. And such organisations and professionals already exist in Greece.

Greece has built experience in the DI area especially through mental health reform. More specifically, in 1995 the Greek Authorities developed a National Plan for Mental Health reform under the code title 'Psychargos'[1]. Psychargos was implemented by public entities, private providers, and NGOs that used a range of different approaches, resulting in varying degrees of success. This reform contributed to developing the workforce, identifying and tackling obstacles to DI, learning from inappropriate DI models, and the unintended negative consequences caused to service users. It helped develop Integrated Housing Services (such as protected apartments, hostels, communal housing) as well as community-based services (such as day centres, mobile units, mental health centres, health and pedagogical centres). Cumulated experience can help build a National DI training programme in social care. Because key principles of DI and considerations when transitioning to community-based care are common for all service users (children, persons with disabilities, elderly persons).

Moreover, professionals and organisations involved in Psychargos have a clear understanding of applying standard guidelines when applying comprehensive DI projects in the Greek context. Therefore, one important pool of trainers can be found in the Federation Argo[3], a federation of service providers (public, private, non-for-profit) for persons with mental health issues founded to coordinate and support the Psychargos programme. Many of the professionals involved in the mental health reform (by participating in working groups at the MoH and delivering services in the field), now work in social care. Those professionals can build a comprehensive training program on the experience and expertise in mental health care in Greece. They can blend and adapt methodological tools, materials and outcomes to create flexible training packs. Apart from experience in all-encompassing DI programmes, there is also experience in some aspects of DI, such as alternative care for children.

Although broad generic training is always useful, equal consideration should be given to targeted training as community-based services are highly diverse. However, there appears to be less provision for targeted training around specific groups of service users and consideration of their particular needs and interests (i.e. methodological tools for the recruitment of foster carers for children with disabilities, personalisation and co-production of services for persons with disabilities, transferring financial resources from institutions to community-based care). In 2015, the University of York participated in a research programme regarding continuing vocational education and training for professionals in community-based settings[4]. They conducted a scoping exercise in seven European countries including Greece, that mapped the extent of training and the assessment of its impact on service users' choice and control in community-based care. The main finding was that there was relatively little specialised training for community-based services currently available in Europe. Still, professionals ask[5] for a higher degree

[1] http://www.psychargos.gov.gr/Default.aspx?ID=26188&nt=18&lang=1
[3] Federation of stakeholders for the psychosocial rehabilitation & mental health ARGO: http://argo.org.gr/
[4] Education and Training in Housing Related Support: The Extent of Continuing Vocational Education and Training in Integrated Housing and Support in the EU. 2015, University of York, Department of Social Policy and Social Work. Available at: https://www.housingeurope.eu/section-87/resources
[5] Focus group discussion, evaluation forms completed by professionals after EASPD's training programme

of specialisation in training to address the particular interests and needs of the children and people they serve in the specific context they offer their services.

Training needs analysis per region and per institution will help organise effective training programmes. A National registry per area of expertise of all public entities, certified private providers and NGOs that organise and deliver training programs in social care would be very helpful. For example, the Social Welfare Centre of Attica -Mitera institution is very experienced in foster care as it has been implementing alternative care programmes since 1950. There are not-for-profit organisations that successfully organise day care centres, respite care for persons with complex support needs, and develop research and training departments. Training to informal caregivers for home-based care to elderly persons is already offered by Greek non-profit organisation. A national registry for certified organisations would ensure transparency and help the Greek Authorities develop a national training and advisory team (or service) that will provide both in-place and long-distance support during the DI reform.

The national training and advisory team should not only include academics and social and health care professionals. The DI project must consist of service users as well[6]. Service users is an underestimated, although valuable resource in shaping and delivering training programmes. Their insights and experiences will help us make the training more effective and demonstrate to participants what rights are in practice and not just in principle[7]. Furthermore, working in partnership with service users at the national training and advisory team level will help the timely development of diverse and flexible, continuous participation strategies. It will help accommodate new ways of working and communicating and rethink power relations between service users and professionals throughout the process. There are many factors to consider when planning and implementing service user participation in service enhancement and change training. The risk of causing unintended harm to people that have already suffered marginalisation can be mitigated if all professionals involved in developing training programmes understand the principles and practice of service users' participation. When service users are empowered and continuously supported by organisational structures, processes and management strategies we can help them experience training as an opportunity for meaningful participation and they can help us make training a success[8]. Selection of service users who will participate in the national DI training and advisory team should be as transparent as it will be for other team members. Service users must be reimbursed for their services on the same terms and conditions as any other trainer.

[6] For more information see: Has service user participation made a difference to social care services? 2004, London, Social Care Institute for Change. Available at: https://lx.iriss.org.uk/sites/default/files/resources/pp03.pdf
[7] The Common European Guidelines on the Transition from Institutions to Community-based Care. 2012, European Expert Group on the Transition from Institutional to Community-based Care. Available at: https://deinstitutionalisationdotcom.files.wordpress.com/2017/07/guidelines-final-english.pdf
[8] See trainer Wendy Perez: https://citizen-network.org/resources/see-me-as-me.html

The main areas of work of a national DI training and advisory should include:

- facilitation of virtual and physical study visits and meetings with national delegations in countries that have made progress in DI (i.e. a delegation from state officers in the Ministry of Social Affairs in the Czech Republic could support state officers in the Greek MoLSA on issues of transferring resources);
- cooperation with university departments that could possibly offer accredited work-based training courses leading to certified professional qualifications in community-based caregiving[9];
- organisation and commission of technical assistance to policymakers and managers and other key stakeholders;
- development of training material and delivery of training in the specialist areas critical for the progress of a national DI programme;
- development of tools and publications intended to assist practitioners and staff with the closure of institutions and the development of new services;
- development of training materials for youth participation programmes;
- planning timely, follow-up training interventions such as consultancy-based training, virtual support and mentorship programmes, networking facilitation etc.;

Vetting training materials, hand-outs, exercises and curricula is a crucial part of the process. The national training advisory teams should work closely with the Steering Committee for DI[10] on this subject, and together they should regularly observe and monitor workshops offered by contractors. Standardisation of training will help limit risks. However, poor execution of quality training programmes is also a risk that needs to be mitigated.

[9] For example, the Cardiff Metropolitan University offers a BSc degree focusing specifically on supported housing: https://www.cardiffmet.ac.uk/education/courses/Pages/housing-studies-bsc.aspx

[10] Already developed by the MoLSA

3.4 Limitations and recommendations

Some of the most important limitations when delivering training programmes are the following:

- Resistance from participants, especially when training is designed as mandatory: when employees feel they are being controlled and assessed, they tend to react negatively. Training sessions should be based on voluntary participation, and effective communication strategies should be in place to reduce the fear that change brings. Internal communications strategies that deliver the right messages timely will help professionals understand that they can actively participate in the newly developed services. Effective communication strategies and ongoing training will help gain and maintain professionals' support during the DI process[11].
- Low-quality training can not only be damaging but also reinforce stereotypes and increase resistance from the professionals to future training programmes: vetting training programmes and monitoring execution is crucial.
- Even the positive effects of 'one-off' quality training can eventually 'wear off'. Deep-rooted stereotypes that lead to implicit prejudices and specific working methods can be changed in the long term with ongoing programmes of intensive training.
- The constant movement of social care personnel around different services will undermine the training process and will make managers more hesitant to invest in training (i.e. we might need to train a social worker currently appointed in child-care on.
- Inadequately budgeted training programmes can lead to low-quality training: focusing on the available resources and not on those needed to deliver DI is one of the most common mistakes across countries that have made progress in closing institutions. In the case of training, this could mean low-cost training initiatives and in-house training only. Base training planning on the training needs analysis and the goals set in the national DI Action Plan.

[11] The Common European Guidelines on the Transition from Institutions to Community-based Care. 2012, European Expert Group on the Transition from Institutional to Community-based Care. Available at: https://deinstitutionalisationdotcom.files.wordpress.com/2017/07/guidelines-final-english.pdf

4. Designing the national DI training programme

4.1 Training methodologies

The nationals DI training programme builds on a train the trainer approach. It should be comprised of a general introduction on the cross-cutting subject areas for every professional involved in the process of DI and targeted service and role-specific training. It should consider professionals' initial education and existing in-service training activities, and it should be developed on the principles of life-long learning[12]. Learning should be flexible and accessible. Although curricula should build on the specific skills needed to implement the National DI Strategy and Action Plan, it is equally essential to help professionals develop skills for human-rights based and self-reflective practices.

Training can be delivered through a mix of:

- out-of-house face-to-face workshops at national and regional study centres[13];
- online study and virtual support and mentorship through e-learning platforms;
- provision for in-house learning for each institution (depending on staff numbers, targeted explicitly to practitioners' support needs).

A variety of methodologies can be used when executing the national DI training programme, some of which include the following:

- Activities and initiatives in non-formal education could prepare the ground for a national DI training programme. For example, campaigns on alternative forms of care for children, film festivals on issues of disability and independent living, public events in preventing child abuse and neglect, conferences on DI, networking -especially with Greek and international organisations and institutions that have good practices to share-, study visits[14], targeted open discussions, consultancy-based training (consultancy is more often targeted to managers and has a legal, managerial and financial focus) mentorship (guidance and support for staff) staff mobility programmes[15] etc.
- Out-of-house seminars draw on a range of traditional methods such as seminars by trainers and assessments (i.e., asking practitioners to create a practice log such as a logistical planning timetable, a communications tool, or complete an assessment framework). Group work on case studies and mock cases (vignettes), workshops, self-reflective exercises.
- Online learning methods via platforms for online courses (offered often in partnership with higher education institutions) include trainer webcasts and an opportunity to engage with trainers and other practitioners via a virtual forum[16]. They offer flexible, accessible remote learning opportunities for training, re-training and upskilling.
- In-house customised workshops that update professionals on combine theory and practice to develop skills needed in a particular environment (i.e. recent policy changes and initiatives and the opportunities these offer to housing-led and housing-like support staff)

The national DI training and advisory team can opt for delivering the training using more than one training methodologies.

[12] Build workforce capacity and commitment (Beer health, be er lives: children and young people with intellectual disabilities and their families. 2010, World Health Organisation.
Available at: https://apps.who.int/iris/handle/10665/107999

[13] For example, the Training Institute (INEP) at the National Centre of Public Administration and Local Government (EKDDA): https://www.ekdd.gr/%ce%b5%cf%80%ce%b9%ce%bc%cf%8c%cf%81%cf%86%cf%89%cf%83%ce%b7/%cf%80%cf%81%ce%bf%cf%86%ce%b9%ce%bb-%cf%84%ce%bf%cf%85-%ce%b9%ce%bd%ce%b5%cf%80/

[14] When physical study visits are not possible, virtual study visits can be effective as well

[15] Such as Erasmus+ which offers excellent opportunities

[16] Some of many online training platforms that develop career-changing expertise and can inspire an online national DI training programme are: Future Learn: https://www.futurelearn.com/, Canvas Network: https://www.canvas.net/, Coursera: https://www.coursera.org/, Udemy: https://www.udemy.com/

4.2 Learning objectives

When participants complete the national DI training programme should:

- Have a better understanding of the evidence base for DI, which makes the case for replacing institutions with community-based care;
- Be able to identify the restrictions and violations of human rights in institutions, willing to join the DI movement and prepared to be part of this change;
- Be able to use a child and person-centred perspective when planning, delivering or supervising social care services;
- Be equipped with tools and strategies for embedding human rights approach more effectively into their workplaces;
- Be more self-reflective, willing and motivated to question their beliefs and try new ways of working;
- Have a better understanding of the major obstacles to DI, realise their role in them and feel empowered to support this process of many setbacks and disappointments -in partnership with service users- until the end.

Although tempting, we would be setting ourselves up to fail if we tried to design an all-encompassing national DI training programme and expect participants to leave the course with comprehensive guidance on the DI process. The national DI training programme should instead introduce this reform and a guide on planning for follow-up training programmes throughout the reform process. Even in this form of multiple training programmes, no training programme can include all there is to know about a subject area, and more content is not always a good thing. Participants should have enough time to process presented ideas, link them with their life and work experiences and engage in a meaningful discussion during the training. Additional information on subjects of interest or subject areas that might come up during the training programme can be offered to participants as further reading.

4.3 Duration of the programme

The duration of the training will depend on the used training methodologies.

For example, a merely online course where participants can learn independently is usually six to eight weeks of group learning. Participants should be expected to invest at least 3 hours per week on their learning. It would be very helpful if participants could have unlimited access to recorded lectures and training material.

In the case of face-to-face (or a mix of training methods) training duration will depend on the number of participants, their background, and educational needs.
Upskilling training programmes are usually designed to run four days on average. This generally means 15/16 training sessions of 1,5 hours each which together make up a 20-hour training material. Introductory and concluding sessions should involve all participants.

4.4 Programme outline

The training programme should be structured around the targeted training subject areas for each group of professionals[17]. These should be inserted between introductory and concluding plenary sessions. In the introduction, we will set the tone of the training, provide background through the evidence base for DI, familiarise participants with the key guiding principles for DI and make a case for this reform. In the concluding sessions, we will explore how participants can meet the challenge and implement guiding principles in practice.
Indicative training progamme outline for caregivers in institutions for children with disabilities:

Introduction	Research Based Evidence for DI
Person-centred thinking[18]	Developing person-centred thinking skills (understanding, empathy, trauma-awareness, respect to the persons' inherent dignity).
Daily Life	Attachment disorders, trauma and the child's behaviours. Communicating with nonverbal children (intensive interaction, visual tools, basic Makaton). Effectively identifying and managing the context of challenging behaviours.
Participation of children in the decision-making process/ supported decision-making	Child-Centred Planning. Working and effective communicating daily experience in interdisciplinary teams. Observation skills, notetaking, keeping daily journals.
Effective safeguarding	Helping children being heard. Helping children with learning difficulties make everyday decisions (tools, strategies, case studies).
Leaving care preparing for independent life and supported independent living	Relationship-based safeguarding (families, School, volunteers, circle of friends) child-friendly apps.
Concluding session	Supporting children to build confidence and a sense of progress. Support them in taking risks to gain a sense of achievement but also to understand the consequences of choices. Support them in developing a network of people who care for them (families, volunteers, classmates).
What is the objective?	Meeting the challenge in the workplace. Moving Forward: working in partnership with children, setting up peer-support groups, using mentorship programmes.

Out-of-house training for caregivers can be followed up (or complemented) by work-based training on specific areas such as lifting and handling children with complex needs (hoist use, slings), feeding and bathing routines, recommendations about independent access to the bathroom and equipment needed etc.

[17] For a detailed outline of training on children's rights see: Realising Children's Rights: a training manual for care professionals working with children in alternative care. 2015, SOS Villages International. Available at: https://www.sos-childrensvillages.org/getmedia/c350d4d7-e40e-43c3-9bd5-3f8f61fa1002/Realising-Childrens-Right-ENG.pdf
[18] For detailed information on person-centred planning see: Guidelines on standard procedures on DI, including recommendations tailored to the Greek context. 2021, European Association of Service providers for Persons with Disabilities (EASPD)

Follow-up training should be based on feedback participants share during the course and in the evaluation forms after the completion of the programme.

Asking participants to fill in pre-assessment forms prior to the course could help trainers have a picture of the group of participants, tailor their training to the needs of this particular set of professionals and assess the effectiveness of the training at the end of the course by comparing pre-assessment forms with evaluation forms.

5. Cross-cutting subject areas

Each sector involved in DI has different training needs, and a national DI training programme should make sure to address them. However, there are some core DI values and cross-cutting considerations[19] that anyone involved in the process of DI should be trained at. This means the social workforce that provides direct services, professionals in sectors that complement community-based social services (such as health, education, and justice), and professionals managing and supervising social care services. A national DI training programme should ensure awareness-raising on those cross-cutting subject areas among those that can influence DI. Consultancy-based training or one-shot sessions with public benefit foundations, donors and the media system should ensure that the rights of all children, persons with disabilities and elderly persons to family and community-based care are understood.
Therefore, the introductory and concluding sessions of the national DI training programme should include the following subjects

5.1 Research-based evidence for the need for a human rights approach to care:

- Impact of institutionalisation on the health, physical growth and development of any child or person in the residential system[20];
- The severe effect of institutionalisation on early brain development[21];
- How institutionalisation exacerbates existing health problems and disabilities and even causes impairments[22];
- Institutional violence[23]: how intrinsic mechanisms on which institutions operate expose children and adults to harm, abuse and neglect[24];
- The long-term impact of institutional life[25](poor life outcomes, behavioural difficulties and internalised disorders)[26];
- Life-long institutionalisation for persons with disabilities (they enter the system as children, and those who survive into adulthood remain in institutions for the rest of their lives[27]).

[19] This section draws on Lumos' Global DI Training Programme. Further resources are available on the Lumos Knowledge portal: www.wearelumos.org/what-we-do/global-training/knowledge-portal
[20] You can find some resources in regard to the pioneering work of Bowlby, Spitz and Rutter cited in references
[21] See The Bucharest Early Intervention Project: https://www.bucharestearlyinterventionproject.org/
[22] The Risk of Harm to Young Children in Institutional Care. Browne, K. 2009, London, UK: Save the Children. http://www.crin.org/en/docs/The_Risk_of_Harm.pdf [accessed 23 February 2016]
[23] The United Nations Study on Violence on Children, 2006. United Nations. Available at: https://www.ohchr.org/en/hrbodies/crc/study/pages/studyviolencechildren.aspx
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5.2 Making the case for DI

- Legal and policy base for DI: the human rights case for DI is established in key international instruments such as the UN Convention on the Rights of the Child (UN CRC), the UN Guidelines for Alternative Care for Children, the UN General Assembly Resolution on the Promotion and Protection of the Rights of Children, the Convention on the Rights of Persons with Disabilities (UN CRPD), the European Convention on Human Rights (ECHR), the EU Guidelines for the Promotion and Protection of the Rights of the Child[28], the UN Principles for Older Persons. Training should focus on the key provisions and the most relevant articles, principles, guidelines, and declarations for family and community-based care to prevent segregation and the safeguard human rights of the most vulnerable[29]. National legal acts that underpin family and community-based care such as the Law on Foster Care and Adoption, the legal base for the development of Small Group Homes. Trainers should try to reinforce the links between guiding principles and articles and the sessions that will follow in the training.
- Analysing the high costs of institutional care for poor life outcomes[30]: misconceptions about institutional care, vested financial interests, financial cost analysis in other countries (data available from countries such as the UK, Estonia, Moldova, Romania, Russia, Slovakia and Ukraine[31]). Highlight that DI is not a cost cutting exercise.
- Learning from experts by experience in DI: this includes mostly service users who have transitioned from institutions to community-based carse but also staff members who supported them in this process. Testimonies of former residents, families and staff members in institutions often cover all the shortcomings of institutional culture primarily in the lives of residents abut also in the lives of staff members. With many countries being more advanced in the process of DI, there is a plethora of research papers[32], short films on DI, documentaries on disability rights[33], and virtual study visits[34] that can be used to inspire participants.
- Demonstrations projects – what works and what doesn't in other countries: sharing with participants specific projects that have contributed to the reform in other countries[35] will help them see how policies can be applied in practice and hopefully engage them.

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[29] For a detailed presentation of the most relevant articles of European and international legal acts see: Developing Community Care. 2011, European Social Network. Available at: http://www.esn-eu.org/developing-community-care
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[33] Crip Camp : a disability revolution: https://www.youtube.com/watch?v=OFS8SpwioZ4&t=196s
[34] https://vimeo.com/354628489?fbclid=IwAR1h39CMEalCHNXWWYJv4w_7Am6H_6aTjvyxltpW48yG9BQynvAbt8jYA
[35] Such as the Community for All - Moldova project: https://www.keystonemoldova.md/en/projects/community-for-all/

6. Targeted training areas

In this section you can find a list of targeted training areas for key stakeholders and sectors, as highlighted in the focus group, interviews and research.

6.1 Policy officers, managers

- Mechanisms on identifying and assessing resources (financial, human and material) scattered around the field of welfare, justice, health, education and local government.
- Tools for planning the transfer of resources from institutions to community-based services (at a country level and for each institution).
- Data collection and evidence-based planning.
- Conducting stock and flow analysis: reasons for admission and discharge, duration of stay, and how various factors (such as ethnicity or disability-related issues, legal status or contact with parents) impact placements, duration of institutionalisation and outcomes of placements.
- Monitoring and inspection systems – national legal provisions.
- Quality assurance, assessment of professional standards: uniform protocols and criteria in all establishments working with people regardless of their legal form.
- Supporting staff in child/person-centred work.
- Monitoring and evaluation of the services provided to children, persons with disabilities and elderly persons (indicators, tools).
- Financial assessment: cost per user of services provided budgets, donations, identification of limits on resources.
- Building assessment: new use of buildings that served as institutions to provide non-residential community-based services (such as day centres, early childhood intervention services, community centres etc.), or other local services (i.e. schools, athletic centres, hospitals) or to be rented/sold and reinvested exclusively to fund the provision of a range of community-based services. A survey on the financial potential of the building will provide information that will assist the planning of community-based services.
- Inter-agency and inter-Ministerial cooperation that would lead to the operational unification of at least the fragmented public law legal entities in a national system of social care.
- Inappropriate models of DI – lessons learnt:
  - remodelling institutional buildings into 'home-like apartments;
  - setting arbitrary targets on the number of children, people that will transition into family and community-based care;
  - developing community-based services independently of institutional closure: countries that wasted time and funds available in trying to keep both systems running
  - Introducing moratoria on admissions to institutions before the new services are in place: the risk in stopping admissions to institutions through legal or administrative decisions. Gatekeeping entry mechanisms;
  - overinvestment in one type of services to replace institutions: with usually these being foster care for children and small group homes for persons with disabilities. Training on how planning financial support and supervision systems for foster care has helped other countries realise that if the same amount of support goes directly to families, many unnecessary family separations could be avoided. Material on how planning for small group homes for large numbers of persons with disabilities not taking into account their personalised needs and wishes has already set people and this reform to fail[36].

[36] Wasted Time, Wasted Money, Wasted Lives ... A Wasted Opportunity? 2010, European Coalition for Community Living, Focus Report. Available at http://community-living.info/wp-content/uploads/2014/02/ECCL-StructuralFunds-Report-final-WEB.pdf

6.2 Health professionals' cooperation with social care services

Once we have ensured that each maternity clinic and hospitals have adequate personnel and that interdisciplinary mobile units are set up to support new parents, children at risk, people with disabilities and older adults, health professionals should be trained on the following:

- Sharing a diagnosis of possible disability during prenatal care. Health professionals should be trained on supporting potential parents to make informed and unbiased decisions on their family's future. Prospective parents should be offered counselling and health professionals should be adequately trained to discuss with parents issues of care and development beyond the medical aspects of each condition.
- Supporting and informing parents of newborns with disabilities at the maternity ward level in after birth diagnosis. Basic training on helping new parents leave the maternity clinic informed the fundamentals of caring for their child with a disability, health, and social care options. Referring new parents to specialised ECI services and peer, support groups.
- Sharing an after-birth diagnosis, supporting and informing parents of children with disabilities in pediatric hospitals when the diagnosis comes after birth (i.e. autism, learning difficulties etc) or disability comes after birth.
- Identifying social vulnerability at the maternity ward level. Health professionals should be trained to identify and support new mothers who are struggling with weak or inexistent support networks and poor living conditions.
- Identifying and handling child abuse and neglect cases: basic child protection training for all primary health professionals. How to set up clear child protection policies and procedures in all services.
- Monitoring families' health: early intervention services at children's and people's homes by interdisciplinary mobile units. National Home Visitations Program for families with newborns.
- Interacting and communicating with children and people with intellectual and developmental (IDD) disabilities and their parents/carers. Medical conditions in children with intellectual disabilities are often overlooked or attributed as symptoms of the child's/person's disability and as such, remain untreated.
- Communicating, cooperating and supporting children and people with complex needs during dental treatment to avoid surgeries under general anaesthesia for minor dental interventions and the risks involved in anaesthesia for some conditions.
- Cooperating in multi-disciplinary groups to identify and address potential risks. To this day there is no unified mechanism for cooperation, communication and referral between professionals working in health and social services (education and juvenile system in the case of children).

[37] See ICH

[38] For a detailed presentation of the areas that need support for a better cooperation of prosecutors' offices and social care services see: Circular of the Prosecutor of the Supreme Court: 'Issues in regard to foster care, adoption and the process of removal of minors' parental responsibility/custody from parents or those who have minors' custody'. 14/06/2021, Prosecutor of the Supreme Court. Available here at: https://eisap.gr/%CE%B5%CE%B3%CE%BA%CF%8D%CE%BA%CE%BB%CE%B9%CE%BF%CF%82-5-2021/?fbclid=IwAR3z59fqReyauYjNkSw_fWZ5uxvxLjTvmoL-erBlK-TQoLUmxsz8Zqe448xU

6.3 Social workforce in education

Social workers and psychologists are appointed in special education but not in mainstream schools. However, they are very much needed in both settings. Provided that all schools have in their workforce or work closely with social care professionals, those should be trained on:

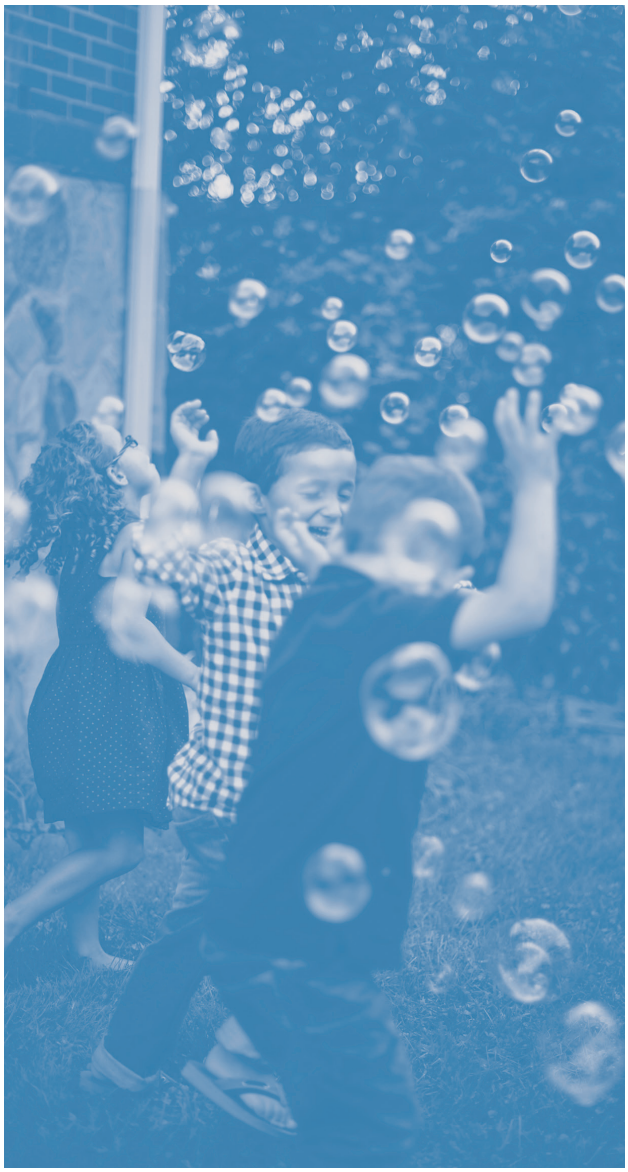
- Identifying and addressing child abuse and neglect and social vulnerability.
- How to educate teachers and all staff members in the school community on child protection issues, safeguard policies, issues of disability and diversity.
- Setting up teams of social care professionals, teaching staff and parents/carers to develop individual education plans. Monitor and support the implementation of those plans.
- Setting up peer support and peer-to-peer activities to help all students meet and interact. These activities can narrow gaps between children of different backgrounds (including children that have additional needs arising from disability), teach empathy and thus improve social cohesion.
- Supporting and empowering children in youth participation activities and self-advocacy strategies.
- Setting up parents' groups, supporting vulnerable families to get involved in their children's education.

6.4 Journalists, opinion makers, influencers, and donors

- The harm caused by institutionalisation and the available alternatives.
- Why institutions continue to proliferate.
- How to make evidence available for the general public.
- Investing in alternative forms of care.

7. Conclusion

A national DI training programme should aim at helping professionals feel less alone, adequately equipped and better supported in this complex reform. Professionals must actively engage in DI which is a dynamic ongoing process and invest time and energy in training. They will have to question and discuss complex issues and areas of disagreement to gain a deeper understanding of alternative forms of offering care.



During the training, they will have to be self-reflective, recognise the biases and implicit prejudices inherent in most humans, and how these penetrate and affect our judgment, decisions, and work practices. They will receive a lot of information, lessons-learnt, tools, methodologies, and strategies. They will be expected to process, absorb and apply them in their workplaces to meet the immediate needs of the children and person they serve and successfully move from institutions to community-based care. This can feel daunting and overwhelming for anyone, especially for professionals and practitioners who have been working in social care services for years with limited support. In the absence of quality support and learning, they might have personalised difficulties and feel they are not doing good enough. Or they might believe that challenges are a direct result of children and people's conditions and there is only so much one can do. Or it can be a combination of both. New, less experienced personnel might already feel intimidated enough by trying to translate their knowledge into practice, and training in DI can make them feel less prepared for a reform of such scale. But what makes deinstitutionalisation a movement of service users, self-advocates, families, advocates, and professionals is the recognition that we all need support to do well. And support should be offered. The workforce in social care is doing challenging, underpaid work, usually in difficult working conditions. While it is important to convey the obligations they have towards the people they serve, they should feel reassured that training in DI is not an assessment and will not impose yet more responsibilities on them[39]. On the contrary, we should help them feel that the national DI training programme is an ongoing support mechanism that will transform lives and create better working spaces and rewarding working experiences.

We are in this together.

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European Association of Service providers for Persons with Disabilities (EASPD), Brussels, July 2021.

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This publication has been produced with the financial support of the European Union via the Structural Reform Support Programme of the European Commission.
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