Technical support on the deinstitutionalisation process in Greece
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Needs assessment protocol developed and adapted to Greek context

Deliverable 7 (as per the Workplan) under Component 2, Output 2.1 Activity 2.1.1 "Development of methodologies and procedures for DI"

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Executive Summary

People respond to changes and moves in different ways. However, research shows that bewilderment, fear and anxiety are common responses, particularly when individuals don't understand why or where they are moving to and professionals lack the support and tools they need to carefully and holistically plan for each individual and address the challenges that this process usually entails.

The purpose of this Needs Assessment Protocol is to provide a research base for promoting and planning the reform of the childcare and social services system, away from institutions and towards community-based services. More specifically this protocol aims to provide information for assessing, planning and preparing children, disabled adults and elderly people for the transition to community-based care and support the interdisciplinary teams of professionals who are carrying out this endeavour.

This Needs Assessment Protocol brings together the actions needed in the assessment process to provide a clear roadmap on:

- How to collect information from vulnerable children and their families, children and adults in closed care.
- How to apply key principles on person-centred care and set priorities when supporting children and adults to move to their new homes and community services.
- How to properly inform the target groups of the current situation, the imminent changes and their choices in the process, empower them to express their wishes and include them successively in decisions that affect their futures.
- How to investigate and analyse the facts on children and adults in closed care and their families or possible caregivers.
- How to plan the actions needed to support each person involved in this process.

We do this by providing:

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- An overview of methodologies that help reduce the impact of transition on the person and help them to settle into a new placement.
- Information on a sample of assessment tools used in other countries and different contexts that have helped professionals build comprehensive preparation programmes where individuals transition as smoothly as possible into a relationship with their family or new carers.
- Information on developing independence and life skills so that professionals can gradually introduce disabled and elderly residents to new experiences outside of the institution.

The Needs Assessment Protocol strengthens the understanding that individual support is at the core of DI. It is the concretization of the fact that everyone in this reform process, both residents and staff members, should have support to help them understand their new situation, give them the opportunity to express their worries and ask questions alongside providing the tools and methodologies to develop ongoing and periodically reviewed individual care plans and effective interventions together.

1. Introduction

Deinstitutionalisation (DI) often tends to focus on systems-planning with individuals being placed in families or community based residential spaces that are available. However, research indicates that the DI process is much more likely to succeed when following a person-centred planning approach in order to achieve individualisation of support and to improve the quality of life of former institutional residents (Holburn, Jacobson, Schwartz, Flory, & Vietze 2004). A focus on individualized and well-coordinated cross-constituency information sharing and planning is essential to ensure that appropriate options of community living are matched to authentic individual needs and preferences.
This needs assessment methodology protocol is developed as an important tool of a person-centred Deinstitutionalisation process, based on European good practices and taking into consideration the resources available in the Greek context.

2. Purpose

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The target groups of this needs assessment protocol are children, children with disabilities, adults with disabilities and elderly persons living in institutional settings in Greece. The needs assessment process will seek to provide detailed information about the person and his/her needs and preferences, which will result in the development of a well-informed personal plan concerning his/her transition to community. Unlike many existing assessment tools solely focusing on physical, mental and intellectual functional-levels, this protocol seeks to take a more holistic approach that reflects all aspects of the personality of the persons concerned whilst being in line with the UN Convention on the Rights of the Child (UN CRC) and the UN Convention on the Rights of Persons with Disabilities (UN CRPD). The purpose of the process is to find out who the person is, not what impairment he/she has. The focus is to empower people to move from congregated settings to their own homes and to enable them to 'live ordinary lives in ordinary places".

3. Key elements

The key elements are:

- Qualified interaction based on equality, patience, respect and inclusion. Meaningful participation of users and of their families, carers or advocates, in decision-making about their future and support services throughout the whole process;
- assessment tools appropriately adapted for different age groups and levels of understanding. Communication adjusted to the needs of the users. Alternative communication tools (i.e. images, symbols, easy to read material developed to ensure the active participation of the user);
- holistic approach, which takes into account each person's strengths and contributions and not only his/her impairment;
- meaningful involvement of people belonging to the circle of natural support of the individual residing in an institutional setting should be pursued where possible as an important resource. The circle of natural support may include family members, relatives, friends, volunteers, etc;
- the needs assessment procedure should be regarded as a continual process, not a single event.

4. Key steps of the needs assessment process

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4.1 Step 1: Formation of the Needs assessment team

The first step of the process is the formation of a participatory, multi-disciplinary team of professionals that brings together a range of skills and disciplines who will undertake the needs assessment process for each resident. The needs assessment team should be part of the larger DI team that will be formed in each institution that is about to close.

These teams should have:

- staff with a range of professional expertise
- strong organisation and coordination

The exact configuration of the multi-disciplinary team will depend on the local context and the population assessing and planning will be offered to. Ideally, the needs assessment team will include existing employees of the institution who are familiar with the residents, as well as professionals specifically hired for the purposes of the DI process.

4.1.1 The Role of the key worker

Throughout the process of assessing the needs of the individuals, a specific person will be allocated to each person as a reference person who will be referred to as the key worker. The key worker will be selected on a case-by-case basis by the needs assessment team on the grounds of his/her competence to successfully play a mediating role which will ensure the wishes and needs of the supported person are expressed and respected throughout the process. The key worker can be a member of the social network of the person, as are friends or family members, or a professional of support services. Ideally the key worker should know the supported person, be able to identify the person's communication style (including nonverbal communication methods when necessary), understand what is important to him/her through a trusting relationship with the person. It is up to the supported person to make her or his own decisions and the key worker's role is to enable and coordinate the necessary resources to implement the decision of the supported person. Empathy, assertiveness and the ability to communicate and connect in a clear and understandable way are necessary soft skills of the key worker.

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4.2 Step 2: Training of the needs assessment team

Each member of the needs assessment team contributes to the process with their unique professional knowledge and perspective. However, the traditional role of professionals as those who unilaterally make decisions concerning the lives of the people they support, offers a limited perspective that restricts the individuals' development and obstructs them from attaining their true potential. Professionals who will participate in the needs assessment team have to be open to modifying traditional patterns and routines, to change and to empower individuals. This implies moving from conventional, institutional culture and only "functional assessment and support", to promoting personal growth and rights-based support.

Every person included in the needs assessment team has to be trained to support their role, in order to be able to understand the whole personalised care and support planning process, including its philosophy. Consequently, they will be able to convey the purpose of the support offered and the role they will undertake in the process to the person it concerns it in a clear and comprehensible manner.

The members of the needs assessment team should have a good understanding of the human rights perspective underpinning the whole assessing and planning process, good knowledge of the available methodological tools of assessment (e.g. Supports Intensity Scale) and training in person-centered thinking and planning methods. (e.g. MAPS, PATH, ESSENTIAL LIFE STYLE PLANNING). Person-centred thinking tools are a set of easy-to-use templates that are used to give structure to conversations and to capture information that feeds into care and support planning, as well as to improve understanding, communication and relationships.

4.3 Step 3: Gathering of existing information

The needs assessment process should take into account information and data that have been collected from previous diagnoses and assessment procedures (e.g. disability assessments like KEPA, residential care records, school records, assessment of educational needs like KESY, ASOA). All existing information recorded (medical records, previous assessments, family-social background records) should be collected and critically examined in order to identify areas where any update is needed, or important information is missing.

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However, the aim of this needs' assessment protocol is to broaden the perspective of the individual's assessment beyond the functional level. Very often needs assessment procedures tend to focus solely on what practical support is needed because of the impairments of the user such as support for hygiene, food, house cleaning etc. All this is also important, but a holistic needs assessment process should focus more on the person ahead of the impairment. The central questions to be addressed should be in the lines of "Who is the person?" or "Who does this person want to become?" and not "Which difficulties is he/she facing?".

4.4 Step 4: Needs assessment meetings

A series of face-to-face structured meetings needs to be organised where the user, his/her key worker, family members and any other person identified as important in the users' life will discuss and develop a needs assessment report for each client. At any point of the process input from specialist professionals (psychologists, occupational therapists, social workers, doctors etc. who don't belong to the needs assessment team) can be requested. The assessment meetings can be a stressful experience for both children and adults for several reasons, so some effort is required to make them feel comfortable. This can be accomplished by carefully explaining the purpose of the evaluation and/or by inviting someone familiar to the person to be present.

The meeting process should ensure that the individual is always the focal point of the planning process. Comments, questions, and statements are to be addressed to the person, whether or not the person communicates verbally. The person's input should be held as primary, and all other participants should act as consultants and advisors rather than decision-makers.

4.5 Step 5: Development of holistic individualised needs assessment reports

4.5.1 Needs assessment methodology for children and children with disabilities

When assessing a child, it is important to remember that he or she is unique with a distinct life history, identity, strengths, and needs. Successful transition into family care and community depends on the careful and informed consideration of all aspects of a child's wellbeing and development: physical, educational, behavioral, social, and emotional.

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As the return to the biological family is always the first goal of social inclusion of the child living in the institution, it is very important that the needs assessment includes both the family and the wider social environment. The Framework for the Assessment of Children in Need and their Families which was developed by the Department of Health in the UK provides a good example of an available systematic toolkit of analysing, understanding and recording all important information.

The figure below shows areas of needs assessed in the context of this tool at the levels of the user, family and community.

1. Age and developmental needs of the child;

2. The ability of parents or caregivers to respond to the needs of the child; and

3. The impact of extended family and community on parenting capacity and the development of the child.

Another useful resource for assessing the needs of children especially developed for the Greek context is the "Methodology of Diagnostic Assessment of the Needs of the Child and the Family" developed by the Institute of Child Health (IYP) and the organization Lumos in 2016. This methodology is accompanied by a standardized tool for capturing the results of the diagnostic assessment, the Social Research-Diagnostic Assessment Form of family and child needs, which was developed in

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collaboration with the National Center for Social Solidarity (EKKA) and the Association of social workers (SKLE).

4.5.1.a Tools to enable active participation of children with disabilities

When assessing the needs of children with disabilities, special consideration should be taken to ensure that the voice of the child is heard and communicated. The basic principle that should underpin the whole process is that all children, regardless of the level of difficulties and impairments they face, can speak for themselves and have the non-negotiable right to live in a socially integrated environment. Achieving this goal requires the use of tools that will facilitate children with disabilities to communicate their desires and needs. A good example of this is communication passports which were initially developed by the CALL center in Scotland and are person-centred booklets, especially developed for children, young people and adults who cannot easily speak for themselves. They are a way of pulling complex information together and presenting it in an easy-to-follow format. Passports help make sense of formal assessment and enable important things about a person to be recorded. Communication passports are used to ensure consistent care in different settings.

A communication passport template and methodology is available here: https://www.cen.scot.nhs.uk/wpcontent/uploads/2017/02/Scope_communication_passport.pdf.
and here: https://education.gov.scot/improvement/practice-exemplars/communication-passports/

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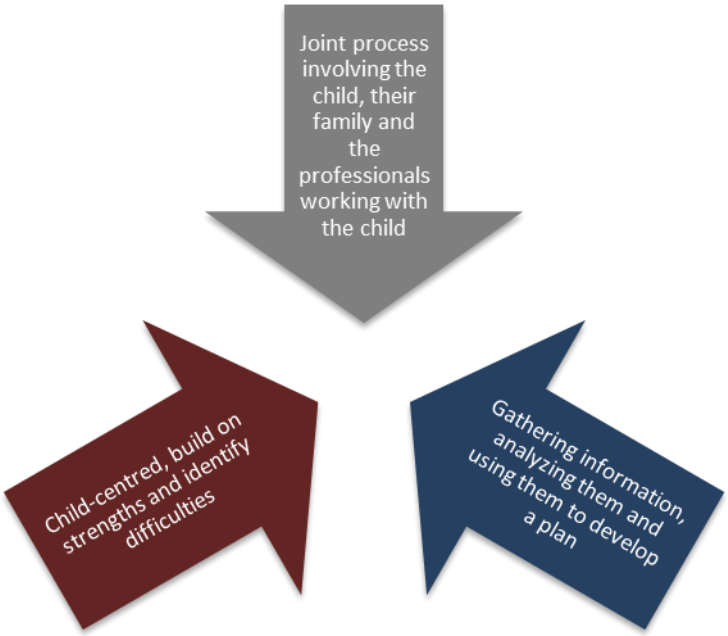

4.5.2 Needs assessment methodology for adults with disabilities

A widely used tool for assessing the needs of adults with disabilities is the adult version of the Supports Intensity Scale (SIS-A). The SIS-A is a standardized assessment tool designed to measure the pattern and intensity of supports that a person aged 16 years and older with intellectual disability requires to be successful in community settings.

The SIS- A is developed by the American Association of Intellectual and Developmental disabilities (AAIDD) and covers the following sections:

- Section 1 Exceptional Medical and Behavioural Needs: Documents extra support needed to deal with specific medical and behavioural conditions.

- Section 2 Support Needs Index: Documents support needs for 57 different life activities. They include:
  - Home Living Activities
  - Community Living Activities
  - Lifelong Learning Activities
  - Employment Activities
  - Health and Safety
  - Social Activities

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- Section 3 Supplemental Protection and Advocacy Scale: Examines various activities the individual performs to protect and advocate for him or herself.

SIS - A is an assessment tool that does not draw attention on skills the individual lacks, but rather shifts the focus *from* deficiencies *to* support needs by evaluating practical support people with disabilities need to lead independent lives. The disadvantage of the Support Intensity Scale is that despite being very detailed with regard to individuals, it does not provide information on the individual's family and informal relationships, which is an important aspect of the planning process.

4.5.2.a Tools to enable the active participation of adults with disabilities

There is a set of recommended tools that can be used to enable and facilitate the active involvement of adults with disabilities in the assessment process.

A good example is the needs assessment toolkit "This is how I manage! My assessment of my need for help and support" developed in 2016 by the Finnish Service Foundation for People with an Intellectual Disability, the Finnish Association for Intellectual and Developmental Disabilities, and Eteva Federation of Municipalities. This comprehensive needs assessment tool is developed in an easy-to-read format, puts the person with support needs in the centre of the attention, and covers the following sections:

PART 1: Who am I? (*My life now, My strengths and skills, People who are important in my life, How I communicate, What I like, What I don't like, My life history, What I want to learn, Situations that are challenging or dangerous for me, The support I get now, What is good in my life right now?, What would I like to change in my life?*)

PART 2: Questions about needs for help and support in the following areas (*Life at home, relationships with other people, work and leisure time and health and safety*.)

PART 3: Summary of all questions in an easy measurable way within the scale (*I don't need support - I need a little support - I need some support - I need a lot of support.*)

PART 4: Comments from family members and carers about my need for help and support.

The needs assessment toolkit «This is how I manage! My assessment of my need for help and support" is available at: https://kvps.fi/wp-content/uploads/2020/04/This_is_how_I_manage.pdf

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Communication passports, previously referred as an assessment tool for children with disabilities, can be also be used for adults with disabilities as a useful tool to facilitate their active engagement in the assessment process.

4.5.3 Needs assessment methodology for Elderly

When assessing the needs of elderly, the following topics should be considered:

- Personal information (Social circle, family and friends, likes and dislikes, hobbies, interests)
- Medical needs (Current and previous health issues, medication, physical health problems, difficulties with mobility, sight or hearing difficulties, problem with incontinence, mental health problems, such as depression, memory problems, diet issues)
- Financial issues (ability to manage finances, benefits and allowances)
- Day-to-day living (Self-care, home care, shopping, community mobility, community-based housing options)

4.6 Step 6: Exploring social inclusion options

While adequately investigating the needs and desires of the individual, it is also important to thoroughly research all available options of the individual's social inclusion, according to his/her age and record comprehensive information on the services that exist in the community. A useful tool at this stage could be the development of a map showing the distribution of services in the region. Such mapping should always be accompanied by an assessment of quality, accessibility and other relevant service features. For children, returning to the biological family should always be the first choice followed by foster care and adoption. For adults with disabilities and elderly all available options should be explored for independent living, for individualised support from a personal assistant or for integration into small housing services in the community such as Supported Accommodation Homes. It is essential to always opt for housing solutions in the area of origin of the person, or where there is a network of natural social circle.

4.7 Step 7: From needs assessment to "Transition to community plan"

Once the assessment phase and the research of available options for community inclusion is completed, the needs assessment team will have a comprehensive idea about the needs of the person, his/her wishes and preferences and information about realistic options of community-based placement.

The next step is to combine this information and together with the person of reference elaborate an individualised Transition to Community plan for each child/adult. This plan will outline a response to every person's needs and preferences

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by identifying which support services and resources will be needed and will clarify all necessary actions to be carried out in order for the individual to transition smoothly from the institutional setting to the community, according to the resources /services/ programmes available in the area.

As with the needs assessment process, the transition plan should engage a team of people involved in the lives of the supported persons. Ideally, the same key worker involved in the needs assessment process should continue playing his/her mediating role during the development of the user's transition to community plan. The main responsibilities of the transition to community team will be:

- to search for materials and tools to help the supported person to understand the information required to make their own choices;
- to support the individual to evaluate the various options;
- to verify that the supported person has understood the pros and cons of the choices involved in a decision;
- to play the role of the advocate who will facilitate the supported person to express his/her choices;
- to record in a concrete and understandable way the agreements for action that are established with the person.

For the individuals concerned, the transition from institutions to family care or community-based services may be an emotionally complicated process. All supported individuals will need to be prepared with special regard to their age and capacity. Proper preparation will minimize trauma and increase the success of the transition by helping individuals to feel confident about the change.

Again, a series of face to face structured meetings should be organised for the user, his/her key worker, family members and any other person identified as important in the user's life to discuss and draft the "Transition to Community Plan". These meetings should be viewed as a forum for communication, negotiation and conflict resolution. The meeting process should ensure that the individual is always the focal point of the planning process.
Comments, questions, and statements are to be addressed to the person, whether or not the person verbally communicates. The person's input should be held as primary, and all other participants should act as consultants and advisors rather than decision-makers.

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In order to design a person-centred transition to community plan, a set of person centred thinking tools is available to facilitate the process and identify do-able action steps in the direction of desirable futures like MAPS, PATH, CIRCLES OF SUPPORT and Essential Lifestyle Planning.

Especially for the context of persons moving from institutions to community-based settings the use of Essential Lifestyle planning methodology is recommended as a way to learn how someone wants to live, and how to make it happen. The process is centred around the individual, their family, and those who care for them. (http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/)

Transition to community plans should not be considered as static documents, but rather flexible plans that evolve as a person's situation changes. For example, the plan for a child placed in temporary foster care will have to change if and when the child moves toward adoption. Two case studies, one of a disabled youngster moving into a small group home and one of child moving into a new family are provided in the Annex of this document.

4.7.1 Transition to community plans for children and children with disabilities

The following elements should be included in a transition to community plan for a child with or without disability:

- needs and strengths of the child and the family;
- relevant support services that meet the child and family's individual needs;
- people or organizations responsible for the delivery of each service;
- a plan for day care, school education or vocational training for children and opportunities for peer participation, including required special accommodations or support services;
- specific, measurable and time-bound objectives and targets to be monitored;
- plan for the permanent family placement of the child when he or she is being placed temporarily.

4.7.2 Transition to community plans for adults with disabilities and elderly

A Transition to Community plan for an adult with disability or an elderly person should contain the following important information:

- Who am I? (My history, my strengths, likes/dislikes, support needs and preferences, communication methods, important people in my life)
- What does Transition to Community Plan mean? (why, when will it happen, where will I live?)
- How will I be supported for the transition? / Who will support me?

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- My rights (What are my rights in the institution? / What are my rights when I leave the institution?)
- What services can I use in the community?
- How will my plan be reviewed and kept up to date?

The transition to community plan should include a user-friendly version in a format suitable for the user (i.e. easy-to-read text, audio, visual mapping etc.) which will summarize the essence of the way forward for the user.

4.7.3 Tools for preparing children and children with disabilities for the transition from institutions to community

During the transition process, it is important for children to be actively involved and properly prepared so that they can share their needs and preferences with their supporters. Lumos has developed two books, one for young children and another one for children aged 8-16, to help children move into their new home and to support children to understand the changes that will happen during the time the institution is closing and how this will affect them.

You can find them here:
https://lumos.contentfiles.net/media/documents/document/2018/01/Moving_New_Home_Younger_Children.pdf
https://lumos.contentfiles.net/media/documents/document/2017/11/Book_2_lowres_21_Jan_FINAL_0.pdf

4.7.4 Tools for preparing adults with disabilities to transition into community

Similarly, adults with disabilities should be enabled to play a key role in the design of their transition to community plan. A useful resource to support this process is the "Independence Pack", a step-by-step preparation guide in easy-to-read format for adults with disabilities moving from institutional settings to community-based housing options. This toolkit was produced with the support of NHS England, Local Government Association, and ADASS, the Association of Directors of Adult Social Services and is available at:
https://www.changepeople.org/Change/media/Change-Media-Library/Free%20Resources/Discharge-Toolkit-TABS-new-buttons.pdf :

4.8 Step 8: My new plan in my new home

After the person has moved from the institution to a family or a community-based service a new person-centred plan should be carried out focusing on the context of his/her new home. Important elements of the initial "Transition to Community Plan"

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could be transferred to the new setting. The core concept is that planning builds upon the individual's strengths and capacity to engage in community activities, while honouring the individual's preferences. Individuals however frail and with any degree of physical, psychological or social issues should be in charge of their lives and the main decision makers about the outcomes they want to achieve.

Again, it should be highlighted that person-centred planning does not end after a plan has been written. Agreeing on a plan is just one stage in the process. What happens to the plan afterwards, and how that is incorporated into the everyday life of individuals, will in many ways determine the level of success of the initial endeavour.

A critical part of the process is the review mechanism which should be regarded as a critical opportunity to reflect and make further changes and decisions. Personalised care and support planning are never a one-off event, but a continuous process of discussion and review reflecting the ongoing changes and priorities in a person's life.

It is very important that the central question of evaluation and monitoring is the quality of life of the individual in his new environment. In this regard, the issues that should be addressed for children placed in families should include the following:

- Are the goals and objectives of the child's care plan being worked on or met?
- How are the child's health and development progressing?
- Is the child showing signs of lack of attachment, poor recovery from any previous delays, difficulty in school, or poor nutrition or hygiene?
- Are the parents or caregivers showing signs of inappropriate behavior management, physical punishment, poor household maintenance and management, substance abuse, or domestic violence?
- How does the care plan need to be adjusted based on the child's development and any new challenges the child or family is facing?

For adults with disabilities there are 2 very useful tools for assessing their quality of life:

- The San Martin Scale Assessment of Quality of life in Persons with Significant Intellectual and Developmental Disabilities which was developed in 2014 and is available here: https://sid.usal.es/idocs/F8/FDO26729/San_Martin_Scale_English_(Verdugo_Gomez_et_al_2014).pdf

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- the INFO FEAP Scale of Quality of life assessment for persons with intellectual disabilities, available here: https://www.researchgate.net/publication/263586850_Scale_INICO_FEAPS_2013_English

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Discharge Toolkit – CHANGE. This resource is a preparation toolkit for adults with disabilities and/or Autism who are living in hospital settings in the UK to support them to prepare to move into the community. Available at: www.changepeople.org/projects/the-discharge-toolkit

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Transitioning to Family Care for Children: A Guidance Manual - Faith to Action. This toolkit provides practical guidance and tools for churches, faith-based organisations, donors and others who are transitioning care for children away from residential care to care within families. Available at: www.faithtoaction.org/family-care-toolkit

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Annex

1. Example case study for supporting a disabled youngster to move into a small group home

Amir is 15 years old and has lived in an institution since he was a baby. His parents only visit him twice a year because the institution is a long way from their home. Amir has a profound and multiple learning disability and due to his complex physical needs, he spent most of his day isolated in his cot bed. The staff said that this was because there was no specialised seating equipment for him, and they did not feel confident moving him. Therefore, he was only moved out of his cot bed for personal care and to attend hospital appointments.

Following assessment and care conference meetings, it was decided that he would move into a small group home close to his birth family.

Amir needed a long preparation programme to allow time to gradually increase his independence and extend his experiences outside of his cot bed, room and the institution. The preparation team began by interacting and building a relationship with Amir while he was in his cot bed. They gradually increased the process of moving and handling him to help him understand that movement can be a positive and social activity.

An experienced physiotherapist and occupational therapist were needed to assess and implement a physical therapy programme and recommend a suitable wheelchair for him.

Amir did not have any personal belongings, so the preparation team provided Amir with some toys which were musical and vibrated. He kept these in his cot with him and took them with him when he moved. These toys were chosen after observing his preferences for colour, texture and sounds.

Other sensory messages were used, for example using the same music and scented hand creams during the preparation programme and then using them again in the new placement. Having familiar sensory experiences in the new home will help children feel safe and secure.

The team had to prepare him for the journey to the new home. Therefore, the team arranged short journeys in the bus to help him get used to travelling.

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Amir was not able to visit the new home before the move as it was too far away. Instead, one of the new carers came to the institution a week before to spend time getting to know him.

The institution carers supported him to gradually take over his personal care needs. The new carer then travelled with him to the new home on the day of the move.

2. Example case study for supporting a child to move into her new family

Daphne is 7 years old and she has lived in an institution with her older sister ever since she was 4 years old. Her mother has learning difficulties and visits her scarcely with the support of other family members. Her father cannot visit his children upon court rule. Therefore, the institution is Daphne's legal guardian. Daphne is an outgoing, cheeky and gifted little girl who loves to dance and excels at school. She is very close to her older sister who is struggling with severe mental issues.

Following failed attempts to place the two sisters together in kinship and foster care a prospective adoptive family has been traced for Daphne. After assessment and care conference meetings, it is decided that Daphne will be separated from her sister and move with her new family.

Daphne and her sister needed a long preparation to allow time to gradually understand how they could maintain their close relationship with proper support from the perspective parents' side and that of the institution. Both of them received one-to-one psychological support. Daphne was supported in dealing with feelings of guilt, fear and anxiety. Experienced psychiatrists, occupational therapists social workers put together a comprehensive care plan for her sister so that she would have an activity programme and a support group that would help her through this process.

Daphne's perspective parents were encouraged to create a book about themselves and the new home where they would include lots of photographs of the home, family and extended family members who they would visit as well as information about what the family enjoys doing. This book was shared with Daphne by her social worker long before her first meeting with her perspective parents.

Daphne's perspective parents were also carefully prepared and assisted in this process. They received as much information about Daphne as possible and spent time getting to know her and her sister. They were introduced to Daphne's routines, everyday life and preparation programmes so that they would feel confident that they could meet her needs when she would move with them.

When Daphne was confident enough to visit her new home, she first went there with a carer who knew her well taking her favourite toy with her. Her perspective parents had been aware of Daphne's attachment struggles and had realistic expectations from those first visits outside Daphne's comfort zone. They focused on having fun through relaxed and positive experiences also allowing time and space for

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Daphne to grieve. Gradually longer periods of time were spent in her new home rather than the institution. Daphne was involved in helping to get her room ready, buying personal things and choosing the colour of her beddings. Daphne's sister remained part of her new life through visits and outings together on a regular basis.

This process helped both Daphne and her parents to get to know each other and develop a secure relationship that resulted to an adoption which was very much anticipated by both parties.

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