



Lifelong  
Learning  
Programme

**EACEA**  
Education, Audiovisual & Culture  
Executive Agency

**HUNGARY**

**RESULTS OF FOCUS GROUP IN HUNGARY**

# **Report on the results of Focus Group in Hungary of “What is essential is invisible to the eyes” project**

## **Second Focus group**

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## 1. INTRODUCTION

**Aim:** to analyze the training needs of the social care-takers who are working with persons with severe Down Syndrome (here after PSD) within Down Foundations services.

## 2. METHODOLOGY

**The focus group** was a targeted interview within a group of 9 professionals, working with PSD.

Participants and the moderators were sitting in a circle so that participants could see each-others

The moderator initiated the topics agreed in advance (by the INV project participants) and encouraged the discussion when it has stopped. The moderator did let the FG participants speak freely, she only acted actively (interruption, saying in, direction), when the group or a person strongly deviated from the topic or she was afraid of losing an important thought or statement.

**Date and venue:** 29–30 March 2013; first day: Egressy út 108/c, Budapest (rented facility), 2. day: Lánymányosi utca 15, Employment Centre

**The workflow:** 1. Agreement in rules, frame and schedule. 2. Agreement in voice recording and anonymity. 3. Agreement in holding the two sessions on two following days.

### **Timing:**

First day:

3 hours session from 9.00 to 12.00

Introduction: 30 minutes (participants have already known each other)

Topic 1: 1 hour 30 minutes

Topic 2: 1 hour

Lunch: 12.00–13.00

2 session from 13.00 to 16.00

Topic 3: 1 hour 30 minutes

Topic 4: 1 hour 30 minutes

Second day:

2 hour session from 10.30 to 12.30

Topic 5: 2.0 hours

Lunch: 12.30–13.30

2 hour session from 14.00–16.00

Detailed discussion and evaluation, conclusions

### 3. PARTICIPANTS

Participant were selected from the employees of the social and educational services of the Down Foundation, such as respite care, day care, adult education and supported independent living: 9 persons. The participants were care-takers, nurses, special-pedagogues, workshop educators and social workers.

Moderator of the meeting: 1 person (Szilvia Janzsó)

Assistant moderators of the meeting: 2 persons (Anna Veisz and Tímea Magyarai)

**Problems** encountered meeting the professionals and relevant for the INV pedagogical model:

- care-takers and educators are not conscious enough, they function by instinct and emotion in spite of the existing detailed guidances and the regular trainings within the foundation;
- care-persons do not apply the tool of empowerment, and if yes, not efficiently enough;
- care-persons act instead of clients to make things easier, not waiting for the slow and not always perfect performance of PSDs;
- care-persons restrict PSD; not taking any risk associated with independent functioning of PSD;
- care-persons cannot find the healthy harmony between love and expectations/requirement from PSD;
- care-persons cannot find the balance between care and friendship, intimacy and distance;
- educators are impatient due to slow progress of PSD;
- educators cannot find the type and level of teaching tools fitting to PSDs capability and talent;
- care-persons and educators do not rely on the existing assessment results of the PSD;
- the resolution of the scale what is used by the professionals for following and evaluating the progress, is too small: they cannot identify the small steps forward.

## 4. RESULTS OF THE FOCUS GROUP

After the introductory phase of the meeting, 5 topics were discussed in the FG, these were the followings:

- Person with Severe Down Syndrome (PSD)
- Relation between PSD and the social professional
- The feeling of limit in the relationship
- Taking care of people with PSD
- Work with people with Severe Down Syndrome

### 4.1 The metaphor

The moderator applied a new metaphor: a flowery meadow, what is nice because of the diverse variety of flowers, the colorful multicity. One of the flowers is the disabled person, not nicer or uglier than any of the other flowers and grasses. All of the flowers need the same: soil, water, and other flowers and living organisms, coexisting well, sharing the wealth.

#### 4.2.a Person with Severe Down Syndrome

##### **Agreed definition of PSD**

There is no concrete definition. The group tried to put together a general definition.

Severe DS is who needs significant amount of help in many of the daily functions, such as learning, living and employment, even in transport, communication, recreational and social programs or dating.

##### **Agreed definition of full life**

The team thinks it is a relative phenomenon. Full means different scale and content for every person. It is based on their own expectation, and on the requirement of their environment (parents, family, school, teachers, care-takers, partners, friends, etc.).

“Full” has more dimensions: a linear time dimension (when will it be full) and a volume (what is the content) which maybe three dimensional. Every person has his or her own time scale and volume as a maximum. This maximal scale could be the “full”. The will and chance to fulfill this maximum is our fate. Considering the topic like this, it is clear that some of the client live full life, and many of the professionals do not. But thanks to the time dimension, it may come in the future.

## **Discussed topics: agreement–disagreement**

We often face the problem, that in another organization professionals say “seriously disabled” for a person, who is similar those, who are called “very good, able for independent life” by us (Down Foundation). Sometimes clients arrive from other organizations with the information: she or he is “able to work independently”. And it means that he or she was able to work at the former place “independently”, according to the well known routine, at a well known place, but is not able to work even with much support in a new workshop with a little bit different tools and materials.

From the point of view of care-takers it is easier to work with a more seriously disabled person, because she or he is a harmonic personality, living in love and peace, than with a frustrated, always unsatisfied less disabled person.

The active care is an important tool, which should apply the methods of empowerment, providing opportunities for doing, acceptance, love, respect for each other.

Main obstacle of the care-takers’ work and the step toward equity is the Hungarian guardianship system, and the guardianship status of most of the clients. It is completely against of our basic theory and practice: “let them to do”, being based on “do not let them to do, but do and decide instead of them”, it requires complete inactivity from the guarded clients. Guardianship restricts or completely hinders development and equity. Empowerment loses its meaning: empowering for what, when nothing is allowed.

Another obstacle may be the family: overcare, keeping the child-status of the SDS, excluding them from decision-making, not letting one to work or having a partner. Even after some training for the families, it is not easy possessing them to cooperate.

Care-takers have serious problems in understanding the poorly or not communicating clients, and in finding out how to help in the adult-life of those who were babies in their families, not long ago.

Care takers have problems with handling and helping sexual problems and love among clients. It has been discussed lengthy.

### *Agreement*

It is relative, but still we need a definition for SDS and full life, and this is given in the summary. It was stated, that SDS should live similar to anybody else.

### *Disagreement*

There was no disagreement in this topics, rather helplessness. Mainly in the sex problem which brought a long discussion. How to ensure intimate environment, how to support programs and dating ethically, which kind of training is ideal (they discussed here the former trainings for clients). Own family and own child for disabled couples: what would be necessary compared to the current situation. Mentioning mainly material conditions, only very few mental barriers (due to lack of time).

## **Summary by the participants, final solutions**

*Severe DS is* who needs significant amount of help in many of the daily functions, such as learning, living and employment, even in transport, communication, recreational and social programs or dating.

**Full life** is based both on one's own expectation and on the requirement of one's environment. The size and content of full life is very different, person-specific and relation-specific. The time-dimension of fulfilling life is free, important is, not to lost the target.

### **Interpreted conclusion**

When the volume of the self-expected and the required (from the environment) is in harmony the person will be satisfied (independent of being disabled or non-disabled), can feel her- or himself well, will be able to develop her or his skills. The time-dimension is something different, and it may help in education and support: it ensures some respite/delay: the target may remain the expected and required (the same in ideal case) maximum capacity of the person, but the final time-point to reach it, is not exactly defined (life-long learning). If somebody proceeds very slowly and the target is too large in volume, it will never be fulfilled, but still the way they move ahead may be nice and promising. From the point of view of trainers, coaches, care-takers and other professionals the size of the volume of somebody's full life is important: the training is efficient if the required size is well estimated (not overestimated and not underestimated) compared to the abilities of the client. If it is underestimated the fulfillment will be reduced, the life will not be a full life, if it is overestimated, the input of trainers will be mostly vast of work.

### **Recurrent key words**

Empowerment, co-operation, guardianship, relatives and family, acceptance, respect, love, opportunity, information for clients, families, professionals, community.

### **Non verbal behaviors**

The participants worked together enthusiastically, such a real work-team. The discussed topic was not always the required one. When the moderator directed the discussion into the right flow, they were able to get back on the track.

## 4.2.b Relation between a person with Severe Down Syndrome and the social professional

### Relations between clients and care-takers

**Most important aspect and the main basis** of the relationship is mutuality. The relation is person-specific from both sides.

*The participants stated that clients* and care-takers are members of a specific hierarchy in their projects (temporary and permanent homes), similar to one in the family, which is a positive and constructive positioning of the concerned persons. The atmosphere in the different supported living homes is familiar, the relationships are informal, caretakers treat clients as partners (GK: but treat!?), but it is also depending on the situation and concrete person-specific relationship.

Two of the temporary home care-takers are also intraday occupational leaders in the workshop, where the clients work, so they have to behave themselves in the workshop as the boss of the client and in the home as a "friend". It cannot be fulfilled properly: requires high distinctiveness from both of the clients and the care-takers.

The group found important to learn and keep the limits and borders, not to let the client "grow on the caretakers' head". The borders and limits should be designated and complied by the care-takers and other professionals.

*The clients, as the care-takers opinion reflects,* know and accept the hierarchy, which provides them kind of safety feeling. The clients use the care-takers as weapons or as kind of an unalterable higher will against each-other. It is absolutely clear for them, who is good for what, what could be expected from the individual care-takers. They behave differently according to the individual requirements of the care-takers, even if the care-takers do not directly influence their activities. Client may adapt also to unspoken expectations, e.g. when X gives the inspection they go the sleep about 22.00, when Y is there, they start to live at the same time.

Care-takers in the permanent homes know the clients well, they are able to let the clients do in general, e.g. decide everything about food and free time, or solve the problems with each other.

Care-takers cannot treat well the over-binding of the clients. it covers both physical and mental over-binding, which should be controlled by the care-takers one-sided. "If the a client cuddles I reciprocate the hug, but it is never my initiative." "When he/she calls me *mom*, I stop her/him, saying, that I do not belong to her/his family."



## **Time dimension in the relation between clients and care-takers**

### **How often does the care-taker deal with the problems and solutions in connection with SDS?**

The big problems do not arise daily or weekly, rather per half years, when seeing the scale of progress as the outcome of the repeated assessment.

On a daily basis the doubts arise, concerned the care-takers daily work: was my reaction correct, was I right, when confronted with the client; was the instruction adequate to his or her age, or did I treat him/her as a child? Have I hurt him or her with my advice to make it differently, etc.

The FG mentioned the responsibility, and the connected decisions. Care-takers cannot discuss every small decision with their colleges or boss.

### **How are the identified problems integrated into the development plans and other professional developments?**

The care-takers are intensively dealing with the problems which arise, they are looking for adequate solutions and fitting tools. They discuss the problems with each other and with their professional leaders.

For example:

1.) G was more times in the hospital recently, and my opinion was that the hospitals medical staff does not treat him adequately: his health condition is going down. I took his clinical-chemical report to the local out-patient clinic and tried to discuss the problem with the family-doctor in charge. The medical doctor assigned G to two specialists. We are waiting for the results. In between we deal more with his health, his nutrition, gets some vitamins and it has the result: he feels better and looks quite good now.

2.) I think over the day every evening: my current problem is, that there are two clients, A and C, who tries to skip and conduct the others, like a very wild boss. I tried many things without effect. Today I tried to speak to them in a very bossy way as they speak to the others. They were surprised very much. Then I explained, that it is bad not only for them, but for everyone, with whom others speak like this. I wait for the effect now...

### **How much time is used for the utilization of the abilities and possibilities within SDS?**

Care-taker spend a lot of time to mine out talents, abilities and experience of the clients. care-takers understand, that we must primarily rely on what exists.

In the supported living facilities care-takers test the clients who is good in which household activities, and then they try to orient them to exercise that activity. When they

have some success in the best known one, they try to learn and exercise the other tasks too, one by one.

J. is very accurate in clothes hanging after washing. She smooths all pieces, so that ironing is not necessary. The others from the residents see that the care-takers are so satisfied with this work and they would like to learn it from J. They asked J. to show them, how to make it so smoothly. And J. taught the others to hang up the clothes. She also corrugates them if the smoothing is not precise enough. P. is good in table setting. All the others would like to set the table like him. The clients learn from each-other.

B. has learned to prepare a cake, so he bakes the cake in every second week. The others are his assistant in cake making. All of them are happy and eat the cake.

### ***The importance of time in the process of care-taking and developing/teaching***

Fulfillment of the whole/full life is proceeding in time. If we have the target, i.e. the person-specific "full life" (defined by the expectation of the client and the requirement of the environment), the direction is clear, the ways can be chosen (dividing the final goal into little sub-goals), the velocity depends on the clients' abilities and ambitions as well as the care-takers' abilities and ambitions.

Even if the progress is slow, every stakeholder can be satisfied if the progress can be measured and the final target can be still seen and estimated when it will be reached.

Burnout, resignation, hopelessness can be avoided when the development measured and followed in time (monitoring) shows a growing trend.

Not only the development of the client is time dependent but the relationship between client and care-taker. It is necessary to follow in the time this process too, to maintain the relationship in the optimal shape.

All kinds of changes (relationship between client and family, client and friends, client and partner, relation of the client to learning, working, living, etc.) should be followed and harmonized: fasten the delayed functions by teaching and training. For example, one has a sexual partner, but cannot unbutton her or his clothing: buttoning should get priority in his/her training.

### **Joyfulness dimension in the relationship**

Professionals of the Foundation like to be together with the clients. It was mentioned and drafted so many times. Honesty, transparency, recognizability are enjoyable. Care-takers can learn about humanity a lot, what is a very special situation. The love, the emotions which dominate the relationships is also rare and special.

The feeling of being important (for the clients), giving support, helping for those who need and accept help etc. are positive and soul-healing experiences for the care-takers.

In summary care-takers get a lot of joy from their work, and it compensates the problems and difficulties. Nevertheless, those who await only joy from this work will be disappointed, because the joy come only after the hard work.

### **Discussed topics: agreement – disagreement**

Relationships between clients and care-takers. Its time-dimension and joyfulness.

#### *Agreements*

Professionals agreed in the stated problems. They agreed in that the relationship between SDS clients and care-takers is very special: hierarchical and friendly at the same time. They agreed that the time dimension is a very important thing, maybe the key factor for managing the teaching and developing of SDS properly.

The solution for the care-takers problems in controlling relationships, defining borders and limits have not been discussed, so that the agreement was complete.

#### *Disagreements*

There were no disagreements; all the different view and opinions were integrated into the group's opinion and the final outcome of the work.

There was some disagreement in connection with joyfulness, because some care-takers thought that every part of the work and the relationship with clients should be joyful, others think, that, similar to other obligations and employments, care-takers should realize, that part of the work is not joyful.

### **Summary by the participants, final solutions**

There is no ready-made recipe for the management of the relationship of clients and care-takers. Care-takers have to really take care, learn every client and establish a person-specific relationship with them. One like the hierarchy, the other not, one needs strong direction, care taker should fulfill it, and stepwise lead the client to independency, independent decision making, etc. To be able to find the best fitting relationship and teaching method, care-takers should have experience, should know many good examples. They think that the case-discussions and case-studies are very important for all of them.

What they get know and experience they integrate into the developmental plan and work. They deal with the actual problems, they are looking for solutions, they discuss the cases and the good practices.

To follow the care-taking/teaching/developing process *in time* is very important and informative, because this can be the basis of the evaluation and analyses of the details, managing the measures and being satisfied with the results of integrated care-taking and teaching.

In summary care-takers get a lot of *joy* from their work, and it compensates the problems and difficulties.

### **Recurrent key words**

Hierarchy, partnership, person-specific, situation-specific, binding, keeping distance, delineation of the borders, relative time dimension, following the process in time, joy in the work, joy, success feeling, learning from each-other

### **Non verbal behaviors**

The group worked together as a team, everybody concentrated during the discussion, they listened to each other, they let speak everybody, they were openminded for each-others thoughts.

## **4.2.c The feeling of limit in the relationship**

**The concept of disability influences the relationship** in general and especially the educational relationship of the professionals, both care-takers and educators / trainers. It is a dilemma related the borderline between being a teacher/educator (more knowledge and one-sided respect) and "friend" (close relationship based on equity, coaching by advising).

### **The difference between looking after and taking care**

All the participants of the FG know well the difference. Looking after is kind of inspection: is not an organic process, it is just lowering the risk by satisfying physical needs following a uniform protocol and not considering individual needs. Taking care reflects a holistic view, it is person-specific, personal relationship-specific, integrates caring, teaching, loving, satisfying physical, mental, emotional and spiritual needs of the clients. The care-taker is not just present but is together with the client.

### **What are the obstacles in care-taking?**

Care-taking and raising/education are going together, but it is not easy to find the healthy limit of taking care and fill the rearing gaps for an adult human. Rearing is interpreted by the clients (also some professionals) sometimes as a negative attitude.

The right attitude from the care-takers would be an exemplary behavior, which is not the specificity of all care-takers.

The physical care-taking is sometimes difficult due to the lack of proper utilities, aminly in the temporary homes, e.g. hoist for bathing, or proper place for eating of a seriously multi-disabled person. The result is, instead of enjoying bathing or eating it may be a torture for both client and care-taker.

### **Discussed topics: agreements – disagreements**

Difference between inspection and care-taking and obstacles in the way of care-taking

#### *Agreements*

Many examples were brought up and discussed to demonstrate the difference between inspection and care taking. The Hungarian governmental system of large institutions was mentioned and compared with the holistic care-system of the Down Foundation.

#### *Disagreements*

There was some disagreement in finding the balance between care-taking and educating, and the different type of educations (raising, teaching, practical learning, motivating, etc.).

### **Summary by the participants and final solutions**

Real care taking is complex and dynamic care, which integrates physical, psychical, educational and emotional care. The holistic care should be person-specific and personal relation-specific, meaning, that the care-taking personnel should share the work according to the roles they play in the community of the home in question. E.g. an elderly woman, filling the role of “mom”, should not educate about dating, partner search on internet and such topics. And the opposite, “raising-type” education should be applied, if necessary, by “mom”.

### **Recurrent key words**

motivation, patience, exemplary behavior

### **Non verbal behaviors**

The discussion reflected the own experience of the care-takers, who wanted to share immediately their knowledge with the others. Everybody was open-minded, attentive and observant.

## **4.2.d Taking care of people with Severe Down Syndrome**

Differences and connections between taking care and looking after in the daily work of professionals and between taking care and relationship. How care-taking and teaching is influenced by the severity of disability?

### **Concept of taking care**

Participants think that real care is raising, education and supervision at the same time. To realize it in a good quality service needs knowledge and attention. The relationship between SDS clients and care-takers is a very close relationship, person-specific from both sides.

Taking care in the above mentioned complex form leads to the deepening of the relationship between client and care-taker. In this relationship care-taker do not calculate, how much is given and what is taken in exchange. This is their work, they would like to fulfil it, in the beginning. But sooner or later they realize, that they get more, than they have given. They also realize that there is a difference between their obligatory giving (workplace duty) and the voluntary giving of the clients. Care-takers rate the voluntarily given knowledge, experience and love higher than the those, which is given given by themselves as a duty. This is new for most of the people.

In the case of the most seriously or multi-disabled clients, whose communication is very much reduced for a simple way meta-communication, care-takers need more time to get to know her or him and understand their signals. These clients often would like to get more attention, some of them can reach to be the center of the attention. When care-takers spend more times with these SDS clients learn to read their signals and get closer and closer to them. Care-takers said: spending a lot of time with somebody, we get to know the person well, and we know well somebody, we get to like this person. This is the first step to a much deeper and more personal relationship.

**Every client is different, so that every relationship is different.** The clients are not just the object of our work, we love all of them. Without emotions care-taking work is empty. Main characteristic of the relationship between clients and care-takers is mutuality: give and take experience, knowledge, love. Care-taking is efficient and successful when the mutually exchanged experience, knowledge and love is much.

### **Discussed topics: agreements – disagreements**

Concept of taking care, relationship between client and care-taker, every client is different, so that every relationship is different.

#### *Agreements*

Most of the topics and the progress in the development of the relationship were discussed in agreement.

#### *Disagreements*

There was a long discussion on the definition and fine-tuning of some terms, such as professional care-taking work, highly professional care-taking, close relationship with the clients, successful care-taking, I like the client, I love the client, I have deep emotions toward some clients, I get a lot from the clients, etc.

### **Summary and final solutions adopted by the group**

The relation ship between clients and care-takers similar to the knowledge, is developing in cycles as the helix model shows. Care-takers and professional have to control the process of relationship-development and channeling it into a professionally acceptable

and ethical way The relationship can be highly personal from both side, but it should be a well balanced one from both side, not turning into pressure and load.

### **Recurrent key words**

Mutual, balanced relationship, metacommunication, give and take, respect, love.

### **Non verbal behaviors**

The participant were very active, they tried to define the terms used and to solve some of the problems. The group cooperated well, they formed a real team.

## **4.2.e Work with people with Severe Down Syndrome**

### **Discussed topics, main agreements, disagreements**

How the severity and age of the clients influence the care-taking and the relationship

### **Discussed topics: agreement – disagreement**

A great number of cases were introduced and discussed, examples of relationships with clients of different ages and severities.

#### *Agreements*

From the examples, the participants came to the conclusion that the age plays similar role than in case of mainstream: the quality of relationship is influenced by the age of the two partners. Ages are associated with some respect and this is independent of the needs of and disability. Ages and severity of the disability does not influence the pedagogical model, but the methods and tools, what can be applied by the professionals.

#### *Disagreement*

Participants were adviceless when speaking about elderly or very seriously disabled SDS persons' education and development: how can be evaluated the slower decrease in the mental or health status on the effect of an educative care-taking? How the care-takers will be satisfied and successful in those cases, when the client goes down in spite of intensive education and care?

### **Summary by the participants**

Participants of the FG have got experience in both fields of elderly and severely disabled persons' care-taking. They think, that the work with elderly and seriously disabled persons is both physically and psychically a hard work, but there are many compensatory benefits, why most of the professionals (in the Down Foundation) voluntarily choose such clients for personal care. These influencing factors are: the high needs and helplessness of these people, the fact that most of them have no other relationships; the relationship with them is seemingly one-sided, but it is not, because the care-takers substitute the other side's interest themselves without abusing or misusing these people. This is kind of

hospice-care or similar to hospice care, with the aim of bringing comfort, self-respect, and tranquility to people in the final years of life. It is more the fulfillment of emotional needs. It is an uplifting human experience kind of holistic support.

#### **Recurrent key words**

Care of elderly, care of seriously disabled persons, turn of duty, humbleness, special relationship, emotional care, hospice care.

#### **Non verbal behaviors**

This topic overloaded the participants, they become sad on the effect of the sad cases of elderly and seriously disabled clients, whom many had died already, or suffers a lot.

## **5. CONCLUSIONS**

#### **Evaluation of the training in general**

The group was homogeneous and very active. They are the best care-takers and other professionals of the foundation, working in four different services. It was a good opportunity for the groups professionals to meet and exchange their experience and opinion. The moderators have got only a few work.

#### **Recurrent key words during the FG 2**

The keywords are organized alphabetically

acceptance, binding, co-operation, care of elderly, care of seriously disabled persons, delineation of the borders, developmental care, educational care, emotional care, empowerment, exemplary behavior, following the process in time, give and take, guardianship, hierarchy, hospice care, humbleness, information for clients, families, professionals and community, joy, joy of the work, keeping distance, learning from each-other, love, motivation, mutual and balanced relationship, metacommunication, partnership, patience, person-specific, opportunity, relative time dimension, relatives and family, respect, situation-specific, success feeling, turn of duty, special relationship.

#### **Concept on the people with Severe Down Syndrome**

Severe DS is, who needs significant amount of help in many of the daily functions, such as learning, living and employment, even in transport, communication, recreational and social programmes or dating.

#### **Concept on the work with PSDS**



The care should be combined with education, development, raising, practicing, with emotional care, etc. The holistic approach integrated with care-taking needs special methods and tools and is based on a person-specific plan. The education is followed in time, and the whole educational cycle is managed by regular evaluation and interpretation as well as control / corrective actions. The relationship between care-takers and clients are followed and monitored in a similar way.

High consciousness of the care takers makes it possible to evaluate the clients on a person-specific relative scale. The efficiency and success is also measured by the progress on this relative scale. Emotional factors are also counted in, mainly in case of elderly and seriously disabled clients.

### **Lessons learned**

Planned educational care instead of instinctive and emotional functioning of care takers is necessary.

### **Training needs on knowledge, skills and abilities for the educational process of people with Severe Down Syndrome.**

Development of the relative standards and the assessment methods of slow and relative progress is desired.

Special therapeutic methods for severe SDS are needed

Case histories, case discussions are very useful

Trainings and education for the professionals;

Ethical education of the professionals

Supervision for the professionals;

Visits of other services within and out of the Foundation

Practical work in other services within the Foundation

Practical work in other organization in HU and in other countries

To take over of the good practice

### **The elaboration of a Pedagogical model in the next WP**

The pedagogical model should be based on the needs of the professionals.

It will give the basics for the more practical part: the methods and tools. The model should include all kinds of SDS and different ages and seriousness. The model should be dynamic and person-centered. The model should deal with the time dimension and phases of the educational care and the relationship between care-takers and clients.

## **General goals of the INV project**

Based on the general model the goal of the project is to create person-specific methods and tools, as well as to give the method for managing the whole process of education from the planning, through assessment, evaluation and control of the pedagogical process, until its replanning to achieve the most efficient educational care-taking for SDS.

## **Non-verbal behavior of the trainees**

All of the participant were very active throughout the two days work. They were enthusiastic, tried to concentrate on the topic in line. Non of them were negative or delivered aversion. Two members of the group interacted with each-other more times, having seemingly contradictory opinions. They were able to redefine the problem and interpret the originally contradictory opinions as two different sides of the same truth. In another case they harmonized their opinions and reached a consensus Their behavior affected positively the whole of the group, increased the activity of the group and channelled the discussion to important new fields. These active discussions provoked diversity in opinions and a multisided approach. The participants respected each-others opinion, thinking together was characteristic during the meeting, the participant were looking for new solutions together.

## **6. ANNEXES**

### **Attendance lists**

Moderator: Janzsó, Szilvia

Assistant moderators: Sebestyénne Veisz, Anna and Magyar, Tímea

#### **Participants**

Szilágyi Veronika, social worker

Szabó Marianna, special pedagogue

Kmeti Petra, psycho-pedagogue

Lucsok Bea, social worker

Kovács Hilda,

Hőnig Kati, social worker

Mester Ildikó, special pedagogue

Magyar Tímea, social worker

Szabados Judit, social worker

## Photos of focus groups

