



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**

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## 1. INTRODUCTION

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

### 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 and encouraged the discussion when it has stopped.

**Date and venue:** 23 February 2013, Petőfi str. 24, Budapest (one of our independent living facilities).

**The workflow:** 1. Agreement in rules, frame and schedule. 2. Agreement in voice recording and anonymity. 3. Agreement in holding all the sessions on the same day in three details with two breaks.

### Timing:

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 hours session from 13.00 to 15.00

Topic 3: 1 hour

Topic 4: 1 hour

2 hour session from 15.30 to 17.30

Topic 5: 1,5 hour

Detailed discussion and evaluation: 30 minutes

### 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

Assistant moderators of the meeting: 2 persons

**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.

## 2. 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

### 2.a Person with Severe Down Syndrome

#### Concept of PSD

It is agreed and understood that PSDs should be considered as anybody else – in theory, but participants stated that to realize it in the practice is not easy and to translate it into practical rules, maybe even more problematic. The practical work requires knowledge about strengths and weaknesses of PSDs, as well as the risks posed on the individual PSD.

The metaphor (only one was used: apple and strawberry) was found highly coherent; it helped to agree the axiom of 'PSD should be considered as anyone else'. Professionals have to interpret correctly that everybody is different.

#### Agreed definition of PSD

In spite of some differences they are people like anybody else, meaning that they have the right completely fulfill themselves, to become independent and autonomous. The lack of skills is a fact. As a consequence PSDs need permanent/regular support in their daily life, in their education, employment, living and decision making. This is why social work uses the term "supported" for all of these activities. The group stated that every people are different and most of the people need help in their life: this is very normal. The remained abilities and capabilities and talents should be assessed and the person-centered development plan should be based on the assessment results.

#### Discussed topics: agreement–disagreement

##### *Agreement*

PSD should have the same rights as anybody else in the mainstream population.

Professionals should follow the normalization principle and know the ways of 'integration' and understand the higher quality of 'inclusion'.

Professionals should support independence and autonomy of PSD.

Which are the obstacles in the application of the theory? – Our own barriers and restrictions.

What could be the solution? – The positive practice is to be learned. Good practice can be learned: participants feel themselves open-minded in this field.

Legal and institutional background in Hungary is a huge barrier too.

#### *Disagreement*

There was no agreement in the definition of independence and autonomy.

They disagreed in: the influence of the scale of disability – some professionals say that equality and normalization principle should be applied independently from the severity of disability; others think that it should be taken into consideration.

Participant did not agree in the suitability of the Hungarian service-system.

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

The statement of “PSD must be considered as a person as anyone else and therefore he/she should completely fulfill him/herself” – it is true, but it does not mean that they can live as anybody else, because they have different abilities and opportunities, which influences the practical solution and the everyday life.

The equality of PSD is recognized by every professional, but they think, that realization equity in the practice is hampered by the low, by bad traditions, by the outdated models instead of the modern, person-centered social model. This latter approach should be disseminated urgently.

One of the obstacles is the barriers of the professionals (care-takers, educators). That can be removed by higher awareness and by taking good practice over. The group is open for training and all kind of education.

The group has dealt with the physical and environmental conditions; participants think that these are out of their competence.

The financial recognition of the professionals and their work was also mentioned here; participants think that it is determined by the countries’ economy and culture and they (care-takers) have no power to change it.

#### **Recurrent key words**

Equality, normalization, care-taking = teaching = co-operating, over-care and over-control, professionals own barriers, time requirement, good practice, abilities and strengths, make the work more interesting!

#### **Atmosphere**

Participants played active role, have listened to each-other, they have reached a group solidarity

#### **Non verbal behaviors**

Attention was expressed by turning with face toward each other. Kind of motionless listening was characteristic sign during this session, which is the indicator of strong attention. Agreement was expressed by still consenting nodding or short approving words.

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

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

### **Time dimension in the relation**

Time plays role in more dimensions. 1. Everything goes slower than in general. Daily tasks, development, learning, etc. Many activities can be tiered down, and fulfill step-by-step. 2. The time spent together: a care-taker may spend more time with a PSD than with his/her own family. 3. Professional workplan can be divided to short and for long-term tasks and should be evaluated on the short and on the long term.

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

The relationship between client and professional was evaluated from both sides. Professionals characterized their ideal relation to PSD with the followings: honesty, love, willingness to help, respect, patience. Individual needs and wishes of the clients should be taken into consideration.

The relation of PSD to the care-takers/educators can be characterized by the followings: clients have a strong opinion about the professionals, which is expressed by them when there is an opportunity, they give a lot of positive emotions, they do not love all of the professionals equally. The professionals play important role in their life. Most of the clients have a favorite care-taker. Some of them have one, whom they do not favor. It is accepted by the care-takers.

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

#### *Agreements*

The relationship is intimate. Emotions play more important role in the relation between PSD and professionals, than in general. Time should be interpreted otherwise than generally and prefer the "slowly but surely" approach.

#### *Disagreements*

Participants do not agree in the acceptable scale of intimacy, they have different opinion on the acceptable limits. Some of them think that their relation to PSD is similar to the relation with a child, others think, that similar to a patient, and some of them say that professionals have to eliminate any dependency from their relationship.

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

There was a consensus between the participants: the caring attitude should be based on mutuality, attention, love, care and understanding. Compliance of these principles in practice is not always successful. In particular, the regulation of proximity-distance, of intimacy, the frame and rules of emotional and physical proximity cause problem.

Participants need education, supervision and competence-increasing trainings. They are afraid of emotional risk from both sides. PSDs are emotionally well developed and

competent, they know the care-takers and trainers well and they know how to relate to them.

The group agreed that they have to adapt better to the slow time-dimension and better utilize the anyway necessary time for teaching. They agreed that care-takers should never do anything instead of the clients, at most together with them, but the best is letting them do alone.

The group confirmed the benefits of the "development log" (electronic documentation within our foundation) and the yearly evaluation of the personal development plan, because it shows the development of the clients and the positive outcome of the developmental activities well.

Professionals should learn to differentiate between their place and role in the organizations hierarchic structure and their role as care-taker or educator functioning directly with the clients in a non-hierarchic structure.

#### **Recurrent key words**

Good relationship, acceptance, friendship, honesty, respect, sympathy, parent-child relationship, touch, intimacy, closeness, distance control, aggression treatment, stepwise development, "slowly but surely", long-term follow-up, satisfaction, "with, not instead", let PSD do.

#### **Non verbal behaviors**

Much lively attention. Staff people look at each other, smiling, expressions of solidarity can be observed. During the debate, even in cases of disagreement they patiently listen to each other.



## 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 the care-takers and the educators / trainers.

### **Discussed topics: main agreements and disagreements**

#### *Agreements*

The development activity should be designed in a person-centered way based on the abilities and strengths of the clients, which is assessed and documented in the clients' personal document-system, available for all care-takers and trainers.

Quality of life of the clients can be improved by forcing as much independence as possible compared to individual possibilities. Teaching should focus on self-services and independent functioning. To ask for help should also be thought, not being an existing skill!

#### *Disagreements*

The harmony between abilities, development and independence cannot always be found, and as a result, the developmental potential of the client is not utilized. The causes were subject of disagreement. The following causes were enlisted: the narrowness of the care-takers, convenience, lack of motivation due to slow development of the clients and burnout. Lack of knowledge on the suitable educational tools is also on the list of barriers. Some of the care-takers are overloaded, having two jobs, or private problems. Material and environmental conditions may fail too. Participants feel part of the barriers out of their competence.

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

Participants summarized their experience that the limits of clients have priority in the beginning, when they begin to work with the PSD and how the possibilities may become dominant later on, when they know the client better and learn to notice and evaluate the slow development. To identify the development is a positive experience. Care-takers and trainers should be able to identify the person-specific targets, to know the tools to be applied for fulfilling the possibilities and to measure the results. They get professional help from the lead pedagogue of the Foundation on group-trainings or personal consultation.

**Care-takers** focus equally on the end-product of the care-taking ('clean hands') and the learning process itself ('hand washing'), missing sometimes the balance between these two (feeling that clean hands are more important than the process of hand washing).

**Trainers and educators** are more conscious; they focus on the adaptation of teaching tools for the abilities of the person in question by preparing easy to read and understand training materials, executing multiple repetition, and many practical work instead of

theory, they create special utilities in aid of efficient learning, etc. On the other hand for educators the 'end-product' ('clean hands') is too practical, not part of the education, sometimes even not visible: they concentrate more on the learning process. The two views should be aggregated. Patience, sustained attention and documentation is necessary for both type of activities (care and education).

### **Recurrent key words**

Trust in the abilities, capabilities and talents, identifying development, preferring independence over dependence, empowerment, encouragement, patience, creativity, accepting the risks of independence, lack of time, tiredness, negligence, stronger linkage between learning process and its practical outcome.

### **Non verbal behaviors**

Intensive reflection, joy of discoveries, creative attitude, impatient desire to comment, shame, planning.

## **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.

### **Differences and connections**

The difference between taking care and looking after was clear for the participants, not only in the theory, but also in the practice. They exactly know that the physical and mental conditions of the professionals highly influence the quality of care-taking. They feel on themselves, but mainly on other colleges when somebody is not on the top in the daily work and slides down to looking after instead of real care-taking.

**Differences between taking care and relationship** did not look a clear issue, being greatly overlapping phenomena in the work of care-takers. Relationship has wider sense than care-taking, but care-taking may cover all kind of relationship in the special case of care-takers and PSDs.

### **How professionals take care of PSD?**

Taking care PSD may be physically and mentally demanding. The task needs experience in nursing, discretion and empathy. Professionals need regular trainings in health care, hygiene, and practical skills to be able to efficiently care PSDs. Care-takers should link nursing with teaching, care-taking with developing, and many others, meaning that they have to be nurses, care-takers, teachers, mothers, sisters, friends, etc. at the same

time. This topic fascinated and intrigued group and the emotions provoked were much above average.

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

#### *Agreements*

The group equivocally stated that the care of and the relationship with very seriously disabled clients gave them a lot of positive experience.

The highest level of professional knowledge and professional skills are needed in the care-taking of seriously disabled clients. Care takers are ready to be trained and learn how to combine raising, education and supervision in a practical and ethical way. They agreed in a high ethical risk in the care-taking of seriously disabled persons.

#### *Disagreements*

There was a disagreement in the causes of the disharmony and imbalance between looking after and real care-taking. Some participants think that there are unsuitable care-takers, who will never “learn” balanced, efficient and ethical care-taking. Another opinion is that the balance and the ethics can be thought: theoretical and practical knowledge is needed to solve care-taking of PSD.

Burnout was one of the disagreed topics. Opinion 1: Those, who burn fast out are not suitable for this profession. Opinion 2. Everybody burns out on the long term. Opinion 3. PSDs are functioning as an anti-burnout agent: their emotional and developmental abilities prevent burnout of those who like people and the profession of care-taking.

Some of the participants raised the possibility that care takers like the work with very seriously disabled persons, because in spite of the physical burden, it is a mentally easy task, PSDs have very concrete needs (in care) and have only little individual wishes, disagreements with the care-takers, the balance in mutuality is shifted on the side of the professional from the very beginning. Care-takers can ‘freely’ exercise their creativity, helpfulness and emotions. They were not able to decide, if it is right or wrong.

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

The concept and rules of care-taking are stated in Down Foundations rules but it should be clarified in details by education.

The difference between care-taking and look-after is clear, they are in qualitative relationship: a bad quality care-taking goes down to the level of looking after.

The relation between care-taking and relationship is mainly an ethical issue; the optimal and ethical balance should be found in a person-specific way, considering the personalities both of the PSD and the care-taker. This topic should be further discussed on a training session.

The issue of care-taking–look-after is related closely to the phenomenon of burnout and participants discussed the causes, symptoms and prevention of burnout.

Participants mentioned those colleagues, who are unsuitable for the work with PSDs. The equivocal opinion was that those, who are unfit, should be sent away as soon as possible, before making troubles in the person or the community in question. They think that „unfit“ ones would not be changed as result of education.

Participants formulated the need for regular education and supervision and regular evaluation of the performance of the care-takers.

### **Recurrent key words**

Integrated care, rising/education and supervision, fatigue = look after instead of caring, prevent burnout, unsuitableness, unfitness, not proper preparedness, burnout-indicators, early warning of burnout, supervision, honest discussion, diverse tasks, more rest, professional competence should be increased

### **Non verbal behaviors**

In this session assistants could observe the most positive collegial gestures, gaze at each other, smiling together, participants recognized each other's voice, which was confirmed with a gesture of friendship between the colleagues sitting next to each other, touch with the hands occurred as well.

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

**Nine cases** were discussed in the group, with focus on relationships between care-takers/educators and PSDs. It turned out that professionals are ready to provide special support for and close relationship with the most seriously disabled clients. Participants are able to identify positive characteristics and abilities even in case of very seriously disabled persons and are able to utilize it as basis of their relationship.

The participants did not cover the recommended default topics in their case-histories, such as how many times a week doubts, aspirations, desires, suffering, dreams from a PDS person are emerged, or how these doubts, aspirations, desires, suffering, dreams tackle in the individual development plans, and how much time the professionals can devote to the realization of PDS potentialities.

Based on the concrete content of the case histories and the general mood of this session, we can see that care-takers initiate close relationship with the most seriously disabled clients, they function as a mentor (the mentor-system is an existing initiative in the Foundation meaning that every client has a mutually agreed mentor, who is more than a simple care-taker rather kind of friend and a link to the outside world), organize individual programmes and take care in the widest sense, being in close relationship with the mentored PSD. The case studies showed that personal care and closer relationship results in positive attitude, better performance and higher quality in the work. The cases prove that care-takers focus heavily on the relationship, the special programmes, developmental activities with their PSD partner, but it has not been formulated in the

session. Care-taker are in favor of less conscious and more emotional tools, which get a space in the foundation's mentor-system. The special relationship between mentor and mentored is based on a mutual relationship. The type of this relationship depends on the personality of both of the PDS and the care-taker and is influenced highly by their age.

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

Out of the description of the nine case studies the topic was not further discussed.

Agreement was found in the fact that care-takers are in favor of the close relationship with seriously disabled clients. Participants told us the interesting conclusion of forming the couples of mentors and mentored ones: seriously disabled clients are almost bought from one another and are always the first ones who were marked by mentors as their potential mentored partner.

All of the participants function as mentors and they have direct experience in the widest interpretation of care-taking. This kind of closer relationship, such as in the Down Foundation's mentor-system can be one of the solutions to make work with PSD easier, more varied, interesting efficient and anti-burnout. They mentioned earlier the risk of the very close relationship, which may cause wounds when terminates e.g. due to employment reasons.

### **Recurrent key words**

Individual care, close relationship, mutual selection of each other, person-specific solutions, additional task.

### **Non verbal behaviors**

The atmosphere was very friendly and intimate during the case histories. Participants focused on emotions, they barely mentioned any professional aspects neither the original questions were answered.

## **The 9 case histories**

1. A good boy, who calls the care-taker: „mami“
  - We have chosen each-other mutually.
  - He cannot speak, but I know, how smart he is!
  - He is often laughing on us!
  - The other care-taker says, that he opened and flourished, since the care-taker in question takes care on him.
  - We look ourselves in the mirror and stick out the tongue.
  
2. Her mother was going to die.
  - She entrusted me... she left her daughter for me...
  - I did not like this women (the mother) in the beginning.
  - I was afraid of her.
  - I learned a lot from her.
  - She died, but I learned the most from her about acceptance and tolerance

3. I have a 25 years old young women in my heart
  - She still has kept her baby-soul.
  - She only needs an encouraging glance or a hug.
  - She is death and mute. I wish being open enough to understand her.
  
4. I selected an autistic boy
  - In the beginning, he did not want to come down into the activity room.
  - Two months were necessary to keep him down for a while.
  - He comes close to me, when we go for a walk.
  - Now, he is able to work during the whole day.
  - Her college: He selected you, because he trusts only you.
  
5. One care-taker selected an autistic boy
  - It is because her son has Asperger-syndrome.
  - They were together in the museum: they feel themselves well together.
  
6. My choice is a person, who needs extremely much attention
  - I am able to calm him down.
  - He was unassuming before, but now he regularly washes his teeth.
  - His mother brought me a box of bonbons saying that she noticed how good it is, for her son.
  
7. An old couple: they could not speak
  - The man died.
  - Neither the woman could speak.
  - She provoked mother's feelings from me.
  - The love was mutual.
  - Her college confirms.

### 3. CONCLUSIONS

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

The group remained homogeneous during its activity, the participants respected and supported each other, the meeting had a highly co-operative spirit. One participant in the group behaved as and „expert“, which was justifiable due to higher education and knowledge, compared to the others, as well as her leading position. This kind of behavior did not influence the group negatively. There were no deep disagreements or conflicts in the course of the meeting, generally consensus has been formed spontaneously and easily, in spite of different opinions in the beginning. All of the participants were active.

The preparation of the focus-group and the preparedness of the moderator and assistants made the FG a fruitful working session. The moderator did not influence the participants with her individual opinion, remained neutral. The answers on the questions were completely open for the participants.

The participants understood the aim of the FG and tried to be efficient and learned a lot from each-other.

#### **Recurrent key words during the FG classified by different aspects**

##### *Status of PSD*

Equality, normalization, abilities and strengths of PSD;

##### *Care and training of PSD*

Care-taking = teaching = co-operating, typical over-care and over-control, stepwise development: “slowly but surely”, individual care, close relationship, mutual selection of each other (care-taker and PSD), person-specific solutions in care and education, additional tasks, such as ‘mentoring’ in Down Foundation;

##### *Relationship*

Good relationship, acceptance, friendship, honesty, respect, sympathy, parent-child relationship, touch, intimacy, closeness, distance control, aggression treatment;

##### *Professional and ethical aspects*

Satisfaction, “with, and not instead”, let PSD do, trust in PSDs’ abilities, empowerment, encouragement, accepting the risks of independence, long-term follow-up, need for method for monitoring and identifying slow development, patience, creativity, integrated care = care-taking + rising/education + supervision, screening unsuitableness, unfitness, not proper preparedness of professionals, need for higher consciousness of professionals, need for education and training, professional competence should be increased; prevention of burnout, burnout-indicators, early warning of burnout, diverse tasks, more rest, regular supervision;

### *Professionals personal aspects*

Professionals own barriers, preferring independence over dependence, tiredness, negligence, fatigue = look after instead of caring, well balanced, relaxed colleagues are needed;

### *Objective conditions*

Time requirement, lack of time, good practice, take over good practice, make the work more interesting and enjoyable;

### *Educational needs*

Increasing awareness of professionals by trainings in the most important topics, such as normalization, integration, inclusion, person-specific solutions in care, development and education, empowerment, accepting the risks of independence, accepting time requirement, need of method for monitoring and identifying slow development, learning and taking over good practices, treating intimacy and aggression properly, higher consciousness of professionals, increased professional competence, prevention of burnout and making the work more interesting and enjoyable are also important tasks.

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

In spite of some differences PSDs are people like anybody else, meaning that they have the right completely fulfill themselves, become independent and autonomous. Given that the lack of skills is a fact, PSDs need permanent/regular support in their daily life, in their education, employment, living and decision making.

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

Main concept of the work of care-taking and training of PSDs is the application of a complex methodology for person-centered care and education, starting with a sorrow assessment of the abilities of PSD, than planning the aims and targets based on PSDs wishes and professionals advices. Executing the stepwise care and development accompanied by continuous monitoring and control, by measuring and following the sometimes slow progress. As care and training is based on a mutual relationship, in parallel to the training plan of the PSD the professionals have to design their own development and training, being able to make a step forward on awareness and consciousness, as well in functioning efficiently. Based on the keywords and professionals training requirement service providing organizations have to ensure trainings for the professionals to make them able to apply the new pedagogical model, which consists of concrete information, good practices and the suitable attitude, behavior and ethics of the professionals. Indicators for the evaluation of the progress both for PSD and professionals are needed. Based on the value of the indicators the whole process can be validated.



## **Lessons learned**

The focus-group was an efficient tool to get an insight into the problems of the professionals working directly with PSDs. Even if the predefined question were not targeted enough (after my opinion) the verbal and non-verbal responses are suitable for characterizing the state of the art in our organization, and reflects not only the locally gathered knowledge and established attitude, the interpersonal relationships, the strengths and weaknesses of the existing internal service-system but at the same time shows well the differences between our complex (holistic) service-system and the out-timed official (state-managed) social care, the inclusive approach of our professionals in contrast with the segregated practice in other places and in the wider community, as well as the hard economic situation which is an additional load on our professionals.

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

Putting together the keywords related to educational needs, the result is a full and proper educational program. We classified the training needs such as 1. concrete knowledge on principles and methods; 2. personality developmental issues to embrace proper attitude, behavior and ethics toward PSD; 3. Good practice and making it available for the professionals.

### *Education of principles and tools*

Increasing awareness of professionals by trainings in the most important topics, such as normalization, integration, inclusion, person-specific solutions in care, development and education, the tools for empowerment, method for monitoring and identifying slow development, treating intimacy and aggression properly.

### *Training to embrace proper attitude, behavior*

Accepting the risks of independence (of PSDs), accepting time requirement, higher consciousness of professionals, increased professional competence, prevention of burnout and making the work more interesting and enjoyable. Find the balance in the relationship with PSDs.

### *Taking over good practices*

Meeting and learning the existing good practices and adapting the good practice to the local conditions and to individual needs. Executing trials, verifying and disseminating the results. Applying the positive exercises on the long term.

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

Based on the findings of the Hungarian FG together with the findings of the other INV participants the development of a targeted pedagogical model based on the assessed needs will be possible. The pedagogical model according to the outcome of the Hungarian FG would consist of three parts:

1. Theoretical training in an interactive form including up-to-date social models and practices, as well as suitable care- and training-tools for PSDs.
2. Personal development training for the professionals, which could include most of the generally targeted activities, such as:
  - improving self-awareness
  - improving self-knowledge
  - identifying or improving potential
  - developing strengths
  - improving wealth
  - defining and executing personal development plans
  - improving social abilities
  - spiritual development
3. Meeting and learning good practice and prepare the plan of it's introduction into Down Foundation's practice:
  - professional practice in other services (inside and outside of the foundation)
  - professional visits in other service providing organization within and outside of the foundation, or in other countries
  - making a plan for the adaptation of the good practice of others
  - proposing its introduction in harmony with the existing services
  - finding the way and indicators for proving its efficiency
  - preparing a study on the selected good practice and its applicability.

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

Improving social inclusion, well-being and full exercise of rights of people with disabilities needs new social and cultural models as well as behaviors toward people with severe disabilities. The most important participants amongst those who are in connection with PSDs are professionals – care-takers and educators – working in social and educational services for people with serious disabilities. Innovative pedagogical models and patterns may ensure not only the development of PSDs, but also the development of the professionals and higher efficiency and quality of the services providing by them. In addition to concrete knowledge, a change in the attitude of professionals and through them the interacting community (family, residential community, mainstream service providers, etc.) toward PSD.

## 4. ANNEXES

### Attendance lists

Moderator: Keszericéné Nagy, Jolán

Assistant moderators: Janzsó, Szilvia and Sebestyénné Veisz, Anna

Participants:

Bitz, Orsolya care-taker – Márka supported living

Csanádi, Edit care-taker – Respite care home, Szalóki

Erdős, Gabriella workshop educator – Day care centre, Szalóki

Jovánovity, Angelika psychologist – Day care centre, Zágrábi

Kaucsicsné Zsóri, Katalin – social worker, Central services

Kun, Ildikó lead nurse – Respite care home, Szalóki

Méhész, Mária care-taker – Andor group-home

Murányi, Sándorné director, leading nurse – Care-centre, Zágrábi

Nagy, Andrea special pedagogue – Respite care home, Zágrábi

Tompa, Tünde workshop educator – Day care centre, Zágrábi

### Photos of the focus group



