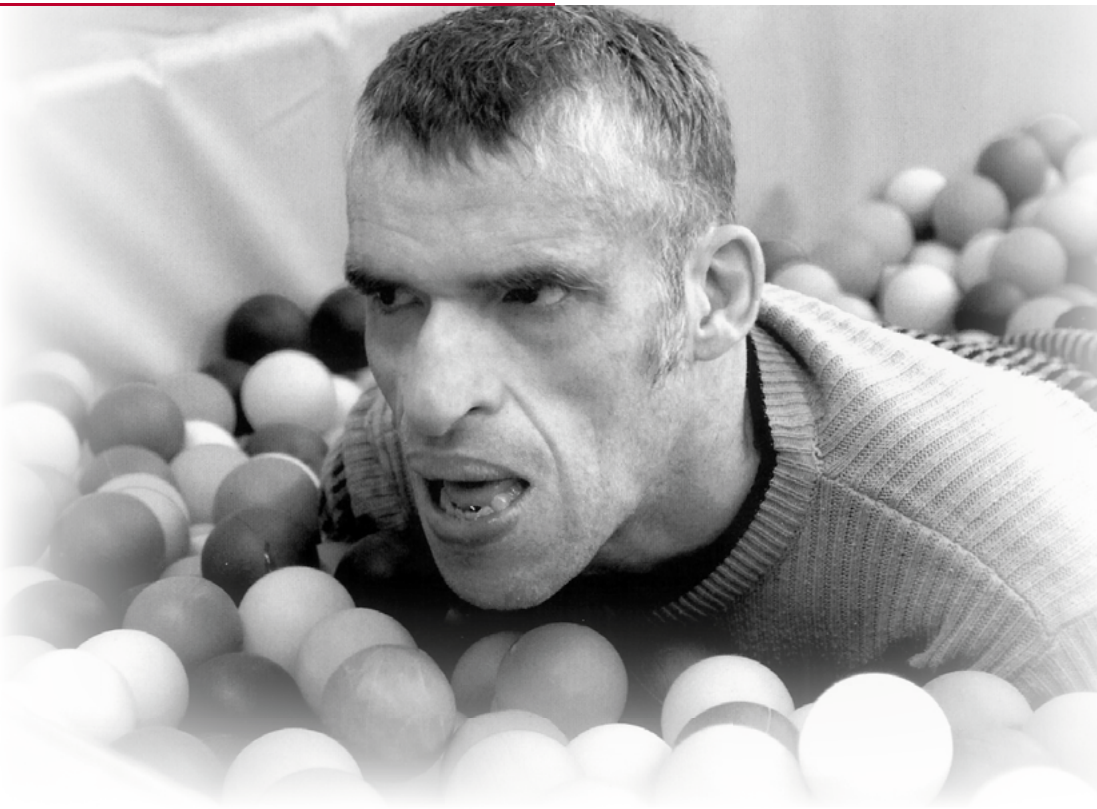
The Netherlands



Care Work with People with Disabilities

Kellebeek College

Education and Culture DG
Lifelong Learning Programme

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Care Work with People with Disabilities in Scotland UK

Content

Introduction

Dear Student

A very warm welcome to the Netherlands.

We are delighted you have chosen to come here for your practical placement and hope you have a worthwhile and interesting time.

The purpose of this booklet is to give you an overview and insight into care work with disabled people in the Netherlands.

This is a very interesting area to work in and there are new initiatives and opportunities developing all the time. Every effort has been made to provide you with up to date information, however you could be made aware and introduced to new legislation, policy and practice during your placement which may have been implemented since this booklet was produced.

There is a lot of information in the booklet which will be of use to familiarise yourself with prior to your visit, also it is hoped it will be a useful reference during your placement.

We wish you a pleasant and enjoyable stay in the Netherlands and hope you have a successful practical placement.

In this booklet we make use of a striking case to illustrate better the described themes concerning the care of people with a disability in the Netherlands. Follow Frans and his family through each chapter.

A boy called Frans,
who is later discovered to have both an intermediate cerebral palsy and a mild mental deficiency, is born into a Dutch family Jansen. In the future, Frans will need a wheelchair to move about and his speech is slightly difficult to understand for those unaccustomed to it. Frans' parents are worried about the future of their son. What kind of possibilities does he have for a meaningful and full life, and how will he cope in this society as an adult?

Good luck!

Promoting the Status and Social Inclusion of People with Disabilities within EU

1. Rights, Status and Social Inclusion of People with Disabilities in the European Union

1.1 The United Nations

Universal Declaration of Human Rights

In 1948 The General Assembly of **the United Nations** proclaimed "**The Universal Declaration of Human Rights**" which is the most fundamental document that also defines the rights of people with disabilities.

All human beings are born free and equal in dignity without a distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory which a person belongs to, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty."

In 1971 United Nations' General Assembly issued "**The Declaration on the Rights of Mentally Retarded Persons**" and in 1975 the "**Rights of Disabled Persons**". Both declarations included normalisation and integration as the guidelines. The aim put forward in these declarations is that of guaranteeing all people equal possibilities of participating in social life.

Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible." (Rights of Disabled People 1975)

Furthermore, the **Rights of Disabled People** argues for their right to necessary services and social protection

"…disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible… and …have the right to medical, psychological and functional treatment, including prosthetic and orthopedic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement

services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration….
…have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment…"
The position of people with disabilities was kept in public awareness by several means. The UN proclaimed 1976 as the ***International Year of Disabled Persons***, calling for an action plan at all levels, from international to regional, for the purpose of promoting the equalisation of opportunities, rehabilitation and the prevention of disabilities.

World Programme of Action Concerning Disabled Persons

After the International Year of Disabled Persons more extensive and specified development took place. The General Assembly formulated the **World Programme of Action Concerning Disabled Persons (1982)** to promote their rights and position in societies on a global level. The programme's agenda was more detailed and focussed. It included a broader approach with expressions such as the"*full participation*" of disabled people in social life and the development of "*equality*," i.e. equal opportunities in a broad sense as well. The programme also defined key concepts such as "impairment", "disability" and "handicap" – and prevention as the strategic objective. Rehabilitation was also defined in a clearer way – as a set of services that function as measures in the facilitation of the disabled persons' full participation and equality. This action plan also put emphasis on education and employment, as well as on removing barriers that often manifest themselves as negative approaches to and attitudes towards this question.

The United Nations' World Programme of Action Concerning Disabled Persons was an action plan for Governments. To provide time for putting the Programme of Action into effect, the UN proclaimed the **United Nations Decade of Disabled Persons 1983-1992**. Governments could implement the Programme within ten years.

At the end of the Decade of Disabled Persons in 1992, the General Assembly proclaimed the 3rd of December as the **International Day of Disabled Persons**. To enhance public awareness the Day has varying themes on issues that are relevant to people with disabilities. **In 2007 the theme was "Decent work for persons with disabilities".**

1.2 The European Union and People with Disabilities

◆ **The European Union** recognises the United Nations' rules on the Equalisation of Persons with Disabilities as the basis for the development of disability policy in Europe.
In 2003 the Commission stressed its belief that the *"emphasis on the rights based approach to disability should be reflected in the evolution of an international human rights standard relating specifically to disability"*.

The EU has specific legal grounds upon which to act in respect to advancing disability rights. Article 13 of the EC Treaties enables the Community to combat discrimination on the grounds of disability. Articles 21 and 26 of the Charter set out the rights of people with disabilities. Article 26, in particular, recognizes *"the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community"* as a fundamental right.

The European Union Disability Strategy stresses the need for a renewed approach, focusing upon the identification and removal of various barriers that prevent disabled people from achieving the equality of opportunity and full participation in all aspects of social life. However, the primary responsibility for action rests with the Member States. The Community Disability Strategy focuses on

- strengthening the co-operation between and within the Member States
- increasing the participation of people with disabilities
- mainstreaming Disability in Policy Formulation

2. The Concept of Disability and Most Common Client Groups

When Frans was a few months old
his parents began to suspect that everything was not as it should be. He did not develop as expected, was in fact a late developer. The parents talked of their concerns when they visited the child health centre that sent a letter of referral to the podiatrist. An examination was carried out which included both medical as well as psychological. It was discovered that Frans had cerebral palsy.

◆ In 1980 the World Health Organisation(WHO)devised a classification system for disability. This interpretation is often referred to as the "medical model" of disability. The definitions are:

Impermaint:	Any loss or abnormality of psychological, physiological or anatomical structure or function
Disability	Any restriction or lack(resulting from an impairment)of ability to reform an activity in the manner or within the range considered normal for a human being
Handicap	A disadvantage for a given individual; resulting from an impairment or disability, that limits or prevents the fulfilments of a role that is normal, depending on age, sex and social cultural factors for that individual.

2.1 General Definition

◆ A disability is a disturbance or a restriction, which causes interference with his/her normal functioning.

Forms of disability:
- ◆ People with a physical disability
- ◆ People with a mental disability
- ◆ People with a multiple disability

2.2 Physical Disability

◆ Definition of a physical disability
A physical disability is a state in which, to a certain extent, one or more interferences lead to permanent restrictions in physical functioning.

Causes
You can split up the causes into two categories

Congenital defects
- Determined by heredity
- Formed during pregnancy (prenatal)

Acquired defects, after birth
- By external influences (accident)
- By internal influences (disease)

2.3 Classifications of People with a Physical Disability

◆ In this booklet we choose a classification based on the nature and the development of a disease. Thereby we can distinguish 4 groups.

Sensory defects
- Visual defects (partial sight / blindness)
- Auditory defects (hard of hearing/deaf)
- Sensibility interferences (hyper-sensitivity or sub-sensitivity for stimulus)

Neurological defects
- Cerebral defects (brain contusion, apoplexy, meningitis)
- Spinal defects (spinal cord lesion, spinal bifida)
- Defects of the central nerve system (MS, Parkinson's disease, epilepsy)

Motor defects
- Muscular diseases (muscular dystrophy)
- Defects of the positioning and locomotor's apparatus (osteoporosis, arthritis, arthrosis)

Organic defects
- Cardiovascular defects (high blood pressure, heart infarct)
- Lung complaints (CNSLD)

2.4 Mental Disability

◆ Definition of a mental disability
A restriction of the mental functions and/ or their further development possibilities (congenital or acquired in early youth); hereby the most striking characteristic is the mental defect, besides social adaptation is made difficult or impossible.[1]

Another definition can be found in DSM-IV (Diagnostic and Statistical Manual of mental disorders; fourth edition, 1995)

DSM-IV gives a definition of 'mentally disabled'. The main characteristics are:
1. In the mental sense people with a mental disability obviously act under the average: an I.Q. of 70 or lower
2. This acting on a lower mental level, results in people's minor ability to adapt themselves to the common things in society. For example concerning communication, self-care or social skills.
3. The disability has to be developed before the age of 18.

Causes
We distinguish the causes of disability as follows:

[1] Gehandicaptenzorg , uitgeverij Angerenstein

Congenital: the disability was developed before, during, or right after birth by

- Hereditary / genetic factors, such as chromosomal deviations;
- Predisposed interferences, leading to brain damage, such as metabolic disease;
- Interferences during pregnancy, such as infectious diseases because of the mother's taking medicines;
- Interferences during birth, such as lack of oxygen;
- Interferences right after birth, such as brain haemorrhage or serious jaundice;
- Interferences in the first year of life, such as meningitis

Non-congenital: handicap developed later in life because of:

- Disease;
- Accident;
- Mistreatment;
- Under-nourishment.

2.5 Classifications of People with a Mental Disability

◆ The group of people with a mental disability is big, so in the care for these people it is common practice to subdivide the group.
In the course of times there have been different classifications. Here are the most recent ones:

Classification based on intelligence

Before, the classification of mentally disabled people was based on their intellectual functioning. Starting point in this classification was the indication of their intelligence in a number:

Classification based on intelligence	*Classification based on acting level (level of mental disability)*	*Classification based on development stages (stages of experience) (Timmers-Huigens)*
IQ lower than 20	very serious	Body-related
IQ between 20 and 35	Serious	Associative
IQ between 35 and 55	Moderate	Structuring
IQ between 55 and 70	Minor	Designing
IQ between 70 and 90	very minor	

the intelligence quotient (I.Q.). This number stands for the proportion between the mental age and the real age. The average IQ is on 100.

In the past, the group of people with a 'very minor mental handicap' was called 'feeble-minded'. In fact we do not count this one to the group of mental disabilities. In the cognitive sense people with a very minor mental disability do not in fact develop differently from the normal-minded, they just do it slower and reach the limit of their possibilities a bit later.

So you can see that the IQ of the several groups is under the average of 100. Hereby a short comment is appropriate. A human being is much more than his/her IQ. He/she has intellect, but also an emotional life, is (not) social, is good at sports and games. And so there are more sides to mention. Someone wit a high IQ can be experienced as egoistic or unpleasant. His or her environment can experience someone with a low IQ as sincere, cordial, or very social. So the concept of 'IQ' does not say that much about the human being as a whole.

Classification based on functioning

Nowadays, in the care for mentally disabled, people with a mental disability are classified according to levels. When defining the level, not only the mental functioning is regarded, but also the social functioning.

Classification based on Dorothea Timmers-Huigens' development stages

In the care for mentally disabled people this classification, based on stages of experience, is more and more in use. At this classification one question is central: How does the mentally disabled person live the world around him/her? What can it do, and what does it do with his/her experiences?

Body related stage of experience
In this stage (between 0 and 1 or 2 years) the child only experiences the world through its own body and senses. A thing that is seen, heard, felt, or smelled by a child at this moment, exists only now. When it is gone, it no longer exists. Of course it is not like that. A pet that is no longer in your bed but in the cupboard it still exists. But a small child does not know yet. It cannot yet make a connection with the environment. The child is 'attached' to its body.

Example:

Marloes is 4 years old. She is curious, but everything seems to be new for her, over and over again. She has a smell at everything and puts it in her mouth. Her favourite activity is staring out of the window. Does she really see anything? Is she aware of what she sees? The counsellors of the group have no idea. Aaltje's main activity is licking on the window, but she also seems to enjoy

the garden in front of her. When the other children in her group get excited, Aaltje begins to cry. Besides, she likes to clamber on someone's lap and cuddles a lot. She knows her group leaders.

In this stage people depend very much on others. Babies and people with a very serious mental disability are in this stage of experience.
This stage is the base for further development. By means of self-confidence and security the child is stimulated to experiment. Awareness of distinction between "me" and "the world" comes slowly.

So the body-related stage of experience is the base and it remains important during the rest of one's complete life. Examples:

- Enjoying a hot shower on your body when you feel cold
- Enjoying sports and movement
- The freshness of a cold drink on a hot day
- Enjoying the sun or seawater on your body on a hot day
- cuddling

All these are body-related experiences.

How can you transform this to the care for mentally disabled people? During the stage of body-related experiences you can think of very basic care for these people: feeding, nursing carefully, cuddling, fostering, whirlpool bath.

Associative stage of experience
In this stage (1 ½ till about 4 years) the child more and more experiences the world in simple structures, associations; an association means, that something belongs to something else. Some examples: a cup belongs to a saucer and "Bert" belongs to "Ernie". And also: 'Mother takes her bag, so we go shopping', 'if I act in this or that way, I am naughty". In this stage a person relates, connects things.

Things can be related as complete sequences or chains of association. As a result, a mentally disabled person with much experience of life, is able to go to his work by public transport, or is able to put the table. These abilities are not based on insight, but on learning the order of things. If anything interferes, the chain is broken and he/she gets into a panic.

Example:
A surrogate family home celebrates its 10th anniversary. As a surprise they all go out for dinner. So that day there is no cooking. Ronald gets excited. When the bus arrives, the group counsellor says: "Ronald, get your coat on, we go out for dinner". On the way to the restaurant Ronald has an outburst of anger and spoils the party.

This associative stage of experience plays an important role as well in our daily. Think about the many things you

do on routine. You do not want to think of reflecting every day again and again on how to get from your bed to your work. You do it automatically. Nor tying your laces needs reflection. And there are many similar examples.

People in the associative stage of experience do make a distinction between 'me' and 'the Environment', but they cannot place themselves in someone else's position. So sometimes they really do not understand what an event means to someone.

And now the relationship with the care for mentally disabled people. In the associative stage of experience we could think of a group climate with a fixed daily program, clear rules and arrangements. The activities have to be recognizable and be repeated. Besides they must be built up in clear steps. Also the room has to be put in order, things must have a fixed place, so that everything is surveyable.

Structuring stage of experience
In this stage (4 or 5 till about10 years) it is all about understanding, analysing, and arranging. You are able to arrange, to survey a structure, to pile tins with a house as a result, to lay a puzzle out of pieces. You discover concepts: under/above, left/right. Sense of duty and responsibility are developed in this stage; you know what to do and that you have to do it. You can do a small job without needing a compliment. In this stage mutual communication is developed as well. You are able to empathize with other people and anticipate future situations, in other words: you can form an idea of the near future. Hereby you can be delighted about what's coming up or you can be afraid of it.

Example:
Marscha is on a special remedial school. Every two weeks on Fridays she goes to the swimming pool with her class. On Thursday evening se always has a stomach ache. Her mother knows that already. On Friday morning she has difficulties to eat her sandwich. Her mother tries to talk with her: "Marscha, you're a very good swimmer. Also last week you were". But Marscha is not looking forward to it, she finds the lifeguard very severe and she is afraid that boys splash water into her face. So she knows what's coming. She is able to form herself an idea.

Now again the transformation towards people with a mental disability, a climate which fits in with people in the structuring stage of experience implies giving insight into for example the 'why' of the daily program, the rules, the appointments. Indeed this is what participants can understand. Also activities, which appeal to one's proper perception, are stimulating. You can also give responsibility to people concerning their own conduct and tasks. You can teach them to make

choices. Within the group you can teach the members to get along with each other by giving them insight in situations and feelings. So in fact your counselling stimulates and supports the taking of initiatives.

Designing stage of experience
In this stage (from 10 or 12 years on) the child develops the possibility to get out of the existing structures; it is able to create something new. Creativity and identity are important conceptions here. 'What in fact is creativity? By designing, the child steps out of fixed, existing structures. Suddenly it is able now to write a computer program or make a self-invented receipt. But it can also concern the way of putting flowers in a vase or spending the weekend.

Most people with a mental disability do not really reach this stage. But for you as a counsellor there is a task here. Working with mentally disabled people often needs giving a stimulus to the inhabitants, so that they will try something new. This is called: designing engagement. This is very important for preventing monotony and a possible regression into a previous stage.

Example:
Femke is 28 years old and she has lived in a surrogate family home for 8 years. Before she lived at home. She has a boy friend in the sheltered workshop. Step by step she started talking to the supervision about her desire to have sex with him.
Together with her the supervision decided that she gets a contraceptive injection. To the complete satisfaction of all, this is functioning well. But then Femke declares that she wants to be sterilized. With good reasons. She says she would never be able to raise a child.

Examples of designing in all day life:
- Choosing clothes (daily and while shopping)
- Choosing hairstyle
- Thinking along with (pleasure) trips, holidays, etc.
- Participate in fixing the hour of going to bed
- Thinking along with and participation in the choice of work
- Right to privacy
- Right to sex education and help
- Etc.

People pass through each stage of experience sequentially. A previous development stage is not left behind, but is the base of the next one and remains vital. It can be compared with an onion, which consists of peals, and every peal is a stage of experience. Stages of experience open up as the peals of an onion.

2.6 Multiple Disability

◆ Definition multiple disability
A multiple disability concerns someone with two separate disabilities, and each of them is serious, huge, and long lasting.

Examples:
Greetje has a mental disability and she is spastic. Jaap has an autistic disturbance and he is bad-hearing.

There are so many combinations of disability, that the situation of each person with a multiple disability is different. .

Causes and classifications, see physical and mental disability

2.7 Learning Disability

◆ In Holland the care for disabled people does not cover children with learning disabilities (dyslexia, dyscalculia, ADD, ADHD, etc). Such children are counselled by teachers and class-assistants on special education schools. You will not be at work on such places.

3. Changing Perspective

3.1 Present, Past and Future

Painter Pieter Brueghel, "The beggar´ 1568.

Antiquity		
Visions	*Period*	**Acting**
The birth of an aberrant child indicates that the Gods are furious	Before the Middle Age (Before the year 1000)	It has to be sacrificed, it has no right to live. By killing the child, the Gods are appeased/satisfied.
A disability is a judgement by God	The Middle Age (years 1000/1500)	It deserves compassion and we have the duty to give it something to eat, drink, and shelter.
People with a disability are possessed by the devil	The Middle Age (Mid)	The devil has to be exorcized
People wit a disability are educated in the wrong way, they can be cured	The Middle Age (End)	It has to be put away and looked after
The person with a disability is aberrant	1780 (Pinel, French doctor)	It has to be treated and aberrant behaviour must be stopped
The person with a disability does not behave normal	1850/1950 (clemency-model)	It has to be re-educated, it needs the right development
The person is sick	1950/1960 (Medical model)	It has to be nursed and looked after

The person has development possibilities	1960/1970 (development model)	Working on the lag by good training and counselling
The disabled person is fine as it is	1970–1990 (integration model)	It needs no doctoring
The disabled person is emancipated and takes responsibility for its own life	After 1990 (care made to measure)	Listen to the individual person and start from its needs and wishes
The disabled person is no longer outstanding, but has a valuable position in society	Future	Disabled persons are supported so they can have a valuable position in society

Before the Middle Ages there was no care for disabled people. In the Middle Ages concern with the fate of mentally disabled people was rising. Churches took pity on the less-gifted and provided for them in the monasteries

Towards the end of the Middle Ages something more was done about the relief of the weak in society. For people who were mentally ill or disabled, madhouses were founded. As a sort of "zoo", these madhouses were opened to the public.

1950: Around this period, inhabitants lived in huge groups of sometimes up to 60 or 100 people, often surveyed by only two sisters. There were dormitories and day rooms. Men and women lived separately. Those who were able to work, had to do so. And those who were not, were nursed. Institutions were almost completely isolated from the outside world. Inhabitants and nurses hardly left the territory. The contact with the parents was minimal.

From 1955 on, the care for the disabled was modernized. It was found out that mental disability had nothing to do with origin or environment. It was no longer one's own fault. Anyone could get a child with a mental handicap.

From 1960 on, the number of institutions increased spectacularly. Diagnosis and treatment were researched. Remedial educationalists and psychologists were engaged by institutions. They tried to teach new behaviour to inhabitants, by means of punishment and reward. Parents were still hardly involved in the care. The fact that institutions were often situated in woods or at sea, did not make things easier.

1970-1974 The "Dennendal" affair:
Dennendal is a department of a psychiatric hospital in Den Dolder with mentally disabled inhabitants. Some chiefs, directors and group leaders, were very progressive. They opposed against group-thinking, sheltering and protection because they wanted to develop the client's individual possibilities. Its director, Carl Muller, wanted small-scaled institutions and dilution. People from outside were to live between the mentally disabled. The authoritarian relationships, ruling the institutions, were strongly criticized. Groupleaders must be able to be themselves. All this led to a great lack of rules at a certain moment. Muller's ideas and styles conflicted with the ideas of people who were working there already long before. After a period of lots of unrest and conflicts the police cleared the pavilion. Nowadays Carl Muller's ideas are generally accepted.

1988 The "Jolanda Venema" affair:
Jolanda Venema was a young mentally disabled woman. In 1988 her parents published a picture of hers on which she was naked and tied with a chain. This was a very chocking picture for anyone. The parents published this picture because they felt desperate.

In many ways they had pride to achieve a decent treatment for their daughter, without any result. But the picture had the desired effect. Money is released, not only for Yolanda's treatment, but also for the treatment of problem behaviour in general. Yolanda appears

Example of the situation if Frans had lived in the 50's
Frans' sister tells: "When we went to get my brother Frans, it took us nearly a whole day. It was an excursion. He was in an institution, 2 hours away from our house. When we were finally there, they received us in a big waiting room. We got coffee and in the meantime a nurse fetched Frans from the group. We never came in his group. That was not strange, it was just like that!"

not to be the only one who is treated in that way.

In the 80s-90s the "Measured Care" model came into being. People with a disability have the right to live in a way which suites them best. Their possibilities are taken into consideration.

Future; the government withdraws more and more as the authority, deciding how and where money should be spent. In 1996 The "Persoons gebonden Budget" (PGB) (Personal budget) was created, so now disabled people can decide themselves where they buy care and how much of it. The government's policy aims at disabled people making use of general facilities as much as possible. It also aims at disabled people living as much as possible at home, independently, or in a small-scaled facility. In the 70s much money was spent on care, so now the government wants to restrict this spending. So developments nowadays do not only deal with vision, but also with making the care cheaper. The new visions are based on supporting the client in realising his/her own wishes.

3.2 Status and Position of the Client

◆ It is a well-known image that someone with a physical disability is dependant and in need of help. People also often create themselves an image that a person with a disability is not able to do whatever anymore and that such a person is helpless. They think things have to be "filled in" for such a person. A confrontation with physically restricted people often evokes feelings of uncertainty and strangeness. Often this is also based on ignorance of and unfamiliarity with the manner of communicating and reacting. They simply have insufficient experience with handling people with a disability. Many still consider disabled people as outsiders. They are far from all having a valuable position in society. We tolerate them, but so far we do not accept them sufficiently. If a disabled person wants to be accepted, he or she must achieve more to come up to the standards, laid down by society. This means: if you want to "join in", you have to be a healthy, beautiful, and achieving person. Thereby it is a matter of one-way communication; then the disabled person just has to conform. Disabled people, mainly those with a mental restriction, get more and more the opportunity to make choices and decisions themselves. Mentally disabled people are not always perfectly able to do so, in many areas.

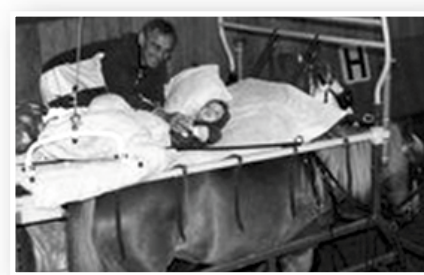
Towards their counsellors, disabled people are in a subordinate position. Sometimes they do not have the courage to fight for themselves, and sometimes they are simply not able to do so, because of their (serious) mental handicap. If somebody is not

completely able to assert, it is important that his/her rights are well guaranteed. In Holland, laws have been made to reinforce the legal position of mentally disabled people. Since the 80s more new laws were made, to even more reinforce their legal position.

Before, concerning the care for people with a mental restriction, attention was focused on "group dynamics"; everything was about done with a uniform approach. Nowadays, the individual possibilities, needs, and wishes of the "cares requestor" are more considered.
Now the personal case history and course of life of the client are better taken into account.
A disabled person has a past, a present, and a future as well. It is also important to look further than today. What will be the clients'/care requestors' wishes and dreams in the future and how do we meet them?
Nowadays, the target concerning (mentally) disabled people is: integration. They have a right to their position in society as well. The way of life, offered to (mentally) disabled people, has to be normal, as normal as possible.

There are three forms of integration
- *Physical integration;* being physically present in society
- *Functional integration;* making use of services in society
- *Social integration;* being accepted as an equal fellow human being

More and more disabled people are residing in the neighbourhood. So they are physically present in society. This is also possible because of getting a Personal Budget (PB). This would imply that separate services and institutions are no longer needed, since people with a disability can make use of regular services in society. According to many people, this image is not a realistic, nor a desirable one. This integration does not prove very helpful to some people with a disability; they feel safer when they can live on their own territory. This has also to do with the fact that they are already living within an institution (and its groups) for so many years. They have experienced its security and they always have had group-mates around them. When a disabled person becomes lonely in a common residential area (for example because of not having the courage to come out), and he/she needs special transport, you will have to wonder if aiming at integration is the right thing. In addition to this, modern society demands people with a high level and a speed of life in an environment full of stimulus. The development level of someone with a restriction implies that the demand



Future perspectives

Frans is living in the group housing in a common neighborhood and working at the …… He has several friends both at work and the group housing. Once a year he goes on holiday with an organization who organizes holidays for people with a disability. Volunteers help him where he needs. Frans also accompanies his parents on a week holiday every year. Frans parents feel secure knowing that Frans has the opportunity to live his own life and that he can get all the support he needs without being dependent on them for practical help in managing his every day life now and in the future

of power and energy exceeds the joy in one's life, in addition to which regression occurs regularly. And assistance by the environment and by experts remains necessary. For example: the wish for ability to do things independently is often not fulfilled.

3.3 The Laws

3.3 The Laws

1800	1900	1910	1920	1930	1940	1950	1960	1970	1980	1990	2000	2005
											(10x)	

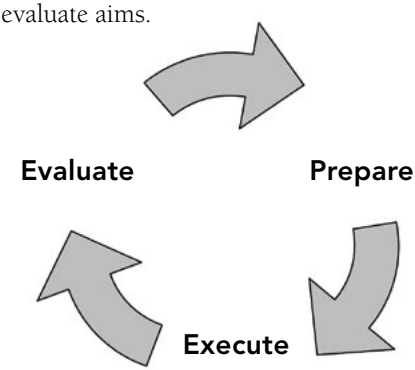
2007	Wmo: (Wet Maatschappelijke Ondersteuning) the aim of the Law Social Support, since 1st of January is to let everybody participate in society. • It arranges support (from their municipality) for people who need assistance in daily life. This concerns services like help with the housekeeping, a wheel chair, or adaptation of residence. • It supports people who are engaged with fellow human beings or neighbourhood. For example volunteers or volunteer aids. • It stimulates activities that enlarge engagement with neighbourhoods and quarters. • It offers support, preventing that people will need more serious kinds of assistance later on. It concerns for example support in education and activities against solitude. P People can address themselves to their municipality for all kinds of support that enable a normal daily life, for example a stair lift if someone is a bad walker. The municipality considers what is the best support for the questioner. Each municipality arranges things in its own way.
1997	WSW: (Wet Sociale Werkvoorziening) Law Job Creation. Meant to create appropriate and valuable jobs for people with a labour handicap. The aim is maintenance, reinstatement, or stimulation of employees' ability to work
1996	WMCZ (Wet Medezeggenschap Cliënten Zorginstellingen) Law Clients Participation Care Institutions. This law arranges the participation of clients (Clients themselves and/or representatives). Examples are: removal, fusion.
1996	Kwaliteitswet zorginstellingen: Quality Law Care Institutions aims at guaranteeing that institutions deliver good quality care. The institutions have to monitor, control and improve the quality of care.
1995	Wet Mentorschap: ...Law Tutorship. This law concerns the interest promotion of people who are will-incompetent.
1995	WKCZ: (Wet Klachtenrecht Cliënten Zorgsector) Law Clients' right of Complaint Care Sector Institutions in the care for disabled people are committed to make an arrangement for the treatment of clients' complaints
1995	"WGBO: (Wet Geneeskundige Behandeling Overeenkomst) Law Medical Treatment Agreement. This law determines the liability of the relief worker to inform the patient or client about nature and target of treatments. It also determines the client's necessary permission for treatments, as well as his/her right to inspect the nursing or care file. All this is to guarantee the client's legal position.
1995	WAO (Wet op de Arbeids Ongeschiktheidsverzekering). Disablement Insurance Act: for employees in service of companies, administration and education who became disabled before1st of January 2004. After this date, instead of the WAO, the WIA "wet Werk en Inkomen naar Arbeidsvermogen" (Law Work and Income after Labour capacity) came into force. The level and duration of the legal WIA-benefit depends on different factors, namely degree of disablement, level of last-earned salary, employment history, and the ability of partly continuation of functioning.
1994	BOPZ (wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen) Law Particular Admissions in Psychiatric Hospitals. This law determines the legal protection against from compulsory hospitalisation of patients. Within the care for disabled people you have to deal with it when means of coercion and freedom-restricting measures are used. For example: isolation, separation, fixation, and compulsory appliance of liquid, food and medication.
1993	BIG (Wet Beroepen in de individuele gezondheidszorg): Law Professions in the Individual Health Care This law makes demands of the use of titles in the Care Sector. You are not allowed to carry out certain technical nursing treatments if you are not registered, such as; giving injections, catheterisation of the bladder, and the insertion of a stomach catheter.
1993	WVG (Wet voorzieningen Gehandicapten) Law Facilities Disabled People. This law aims at promoting the social participation of disabled people. () transport facilities, wheelchair facilities, housing adjustments.
1975	AAW (Algemene Arbeidsongeschiktheidswet) General Disablement Law. This law determines that all inhabitants of The Netherlands are insured against the financial consequences of long-lasting disablement. People with a mental disability, if they are unable to work, are entitled to a benefit from the moment that they are of age.
1968	AWBZ (Algemene wet bijzondere ziektekosten). General Law Special Medical Expenses is a social insurance. In The Netherlands nearly all facilities for disabled people are largely paid for by the AWBZ.
1949	Differentiation regulated by law. This arranges that children with epilepsy and children with a light or a mild mental disablement go to different schools.
1841	Krankzinnigenwet (Law for Mentally Deranged People): Mentally ill people are entitled to nursing and have to be cured.

4. How to Meet the Needs of People with Disabilities

Regularly the parents take Frans
to a specialist. Recently he also gets physiotherapy to train his muscles and balance. To support the parents' care for Frans, the homecare gives them a hand. Frans also had contact with the aid centre for other articles such as wheelchairs. He also met with a speech therapist on a regular basis to help with his speech.

4.1 Methodical Approach

◆ Is a fixed, well-thought manner of acting to achieve a certain aim. You put steps according to a fixed pattern; you are going to set, prepare, execute and evaluate aims.



4.2 Counselling

◆ Counselling is: a professional execution of a whole of activities, helping a client with the resolution of his/her problem

Activities: While being in touch with a client, you execute activities. The contact can be direct (face to face), for example while giving information, helping, supporting, etcetera. It can also be indirect (not face to face), for example while preparing for an activity, team discussion, making a report, etcetera.
The activities are (in) directly focused on the well being of an individual client or a group.
Professional; by receiving an education you dispose of the necessary expertise and ability.
That also implies having a professional attitude; in the execution of your profession you behave in a certain way.

Helping with the resolution of problems
We know 5 categories of problems concerning welfare deficiency: physical, mental, material, social, or cultural welfare deficiency

During the counselling you will nearly always be focused on solving (a combi-

nation of) these 5 categories of problems. You will also often have to deal with a combination of problems, because they are influenced by one another

You can help in different ways. During the education and especially while gaining practical experience, you learn which way of helping is the best. You learn "to play" with it. It is also important to know your target group and to know about the habits within an institute.

4.3 Counselling Method

◆ When you know about methodical working and counselling, you can look at a counselling method. Various counselling methods are possible, depending on the target group. In general all counselling methods have a fixed structure. So therefore the same method is used as described with picture 1, see methodical approach

Stage 1 preparation
The preparation stage consists of a number of steps in a logical order

- Collecting and analysing information
- Defining the need or problem
- Formulating targets
- Planning activities and needs
- Checking target, activities and needs

You start collecting and analysing information about the target group or about the individual client; you can get this from the documents, or from talking with clients/clients' relatives or with colleagues. Furthermore, within many institutions there are also (daily) reports with information about the clients.
After having collected the information you start making an analysis and you take a look at the things that are striking and at the points of which you think that they need special attention.

After having finished the analysis, you start defining the need or problem. One method of counselling starts from a need and in another method it is called problem. So then you examine which term is used within an institute or organisation. The need is a desirable situation; it is an important specification for the next step.

You start formulating targets; the target is to discontinue the actual situation and to create the desirable situation (=need). The target is achieved with the achievement of a desirable situation. When formulating the targets, you also have to name time periods, within which targets have to be achieved.

After having formulated the target, *you start planning activities and means that are needed to achieve the target.*
Examples of *activities*:

- give assistance in doing things, respectively in doing them together and more and more on one's own
- offer adapted play materials

- have talks (advising, informing, problem solving)

Examples of (adapted) *means*:

- play materials, books, television, room, etc.

You check the target, activities and means; this is the last step in the preparing stage and it consists of checking. In a critical way you verify again if the targets

- Logically fit in with the need,
- Match with the expectation of the client,
- Fit in with the vision of the institution,
- Are well formulated without holding lacks of clarity

Stage 2 the implementation

In this stage you carry out what is agreed.

At the implementation you take into account:

- All aspects of your professional attitude
- Procedures and instructions, effective in the institution
- The appropriate appliance of social skills
- Environmental influences

Environmental influences are circumstances that are not completely predictable. Sometimes the target appears not to be well formulated, or the time planning is too limited. These are environmental influences, which cause that the target is not achievable. So then adjustment of target or time planning has to be considered, in consultation with colleagues, executive and client.

Stage 3 evaluation and adjustment

The evaluation takes place when the agreed time planning has passed by. Evaluation is not only a personal but also a collective activity, with colleagues and if possible with the client.

For each target you check if

- the target is completely achieved
- the client is satisfied with the result
- the way of achieving the target was right
- the time planning was right
- the target or time planning should not be regularly adjusted between times
- the appropriate activities were chosen for that target
- the appropriate means were chosen
- the means were well geared to the target and activities

If this all is well done, you can say that the target is achieved. Then you still have to pay attention and take care that the patient will not slide back into the old situation. When the target is not achieved, you will have to adjust it. With that it is important to find out the cause of the no achievement of the target. When adjusting the target, you can take the causes into account. When you adjust the target, a methodical cycle arises. The pattern of "target – execution – adjustment" repeats itself until the target is reached, or until that the decision is made to drop the target and formulate a new (achievable) one.

4.4 Working with a Care Plan

◆ The care plan is an important methodical document, for example in care service and counselling. So when making a care plan, you work by means of a fixed method. This fixed method consists of 6 steps:

- collection of data
- specification of the demand for care
- formulation of the targets
- planning the care
- execution of the care
- evaluation of the care

Collection of data
You start collecting data and information. In this stage the creation of an image of the client is important. By asking questions to the client and/or family you try to collect as many data as possible, not only about events but also about the client's perception. In this way you try to get his/her life story as complete as possible.

Specification of the demand for care
When data are collected, the demand for care can be specified. What is important to this client, where does he/she need support/counselling/help? In specifying the demand for care, the possibilities and wishes of the client are the starting point. Not all clients with a mental restriction can indicate what their care for demand is. In this the counsellor takes over the responsibility.

Formulation of the targets
First of all you take a look at the client's future and ambition. In here, looking at practicability is not even needed; limits are possibly introduced in a later stage. It is indeed important that your image about the future matches with the client's and the parents' image, or with the legal representative's. Because starting from this image, care and counselling targets are formulated. When formulating the main target, the vital question is: what do the client, or his/her parents or legal representatives want to reach with the care? A main target is fixed for a longer period and is effective for everybody involved in the care service. After that working targets (or actions) are made. They can be different for each area and discipline.

Care planning
In here it is especially important to make clear arrangements. It has to be clear who does what, when, how, and with what. You also have to think of registration of the results. You have to record what you have reached or how things went on.

Executing the care
You start working and take care for an appropriate registration of the results, writing things down as accurate as possible.

Evaluation of the care
A care plan is never finished. So during the care process you have to evaluate regularly. You evaluate the targets,

the main target and working targets (actions). And you evaluate if the perspective already comes closer. An evaluation can imply a settlement of a new perspective
And new care targets with new working targets (actions). It is important to appoint the moment of evaluating the targets.

In fixing the targets, many use the "**SMART – method**".

S – specific, targets must not contain woolly statements, but have to be formulated concretely and clearly.

M – measurable, you must be able to check, measure, if the target is achieved.

A – acceptable, targets must fit with clients and organisation

R – realistic, targets must be achievable

T – dated targets must be bound to a time-limit; when will the target have to be achieved?

Or with the **RUMBA-criteria**
The RUMBA-criteria can be used to make the quality of nursing care measurable and allowing.

R – relevant, the nursing target has to be important in relationship to: the nursing diagnosis, orientation towards the care question, the different steps that have to lead to the appropriate solution, from short to long term.

U – understandable, the understanding of a nursing target implies that both, nurse and care questioner; know what it is all about. The criterion understanding is also related to the fact that colleagues or other relief workers know, what a certain care target means

M – measurable, care targets can only be formulated in measurable terms, when vague formulations are avoided. Measurable implies the use of concrete specific terms.

B – behavioural, formulating care targets in perceptible behaviour. For example, it can be very difficult to formulate short-term targets for a mentally disabled care questioner, which leads to a change in perceptible behaviour.

A – attainable, formulated targets must be attainable or realistic.

Comments on the use of the RUMBA-criteria:

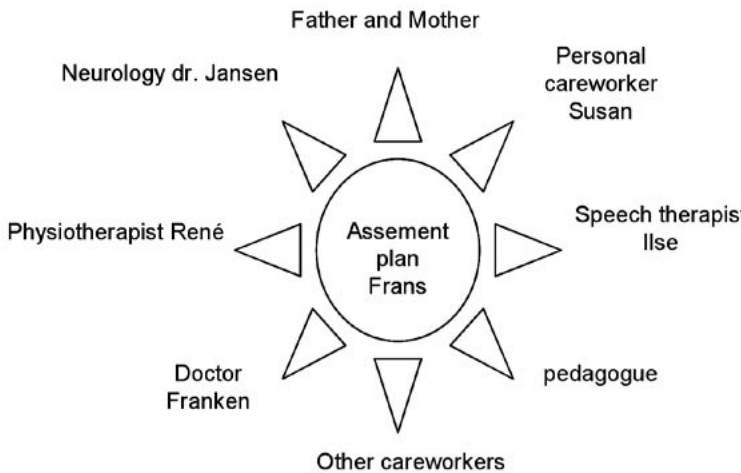
- is meaningful, only if all five criteria are employed.
- A target must be formulated clearly; aiming at perfection is not necessary.
- RUMBA is not a target on its own.

Many institutions work with there own (electronic) care file. Various sorts and versions are available, like Unit4-Agresso www.unit4agresso.com (available in English)

So in this booklet you don't find an example because there is not one national care plan.

You always work with the methodical approach in the care plan as you can see in the beginning of this chapter

Once a year there is
multi-disciplinary consultation, to guarantee that Frans' care plan remains actual. Hereby the care plan and the relevance of his demands for help are evaluated.



4.5 Communication Means

◆ For an appropriate counselling it is important that a client is able to tell about his needs, dream, or care demand. So communication is vital. Therefore below you find a description of communications means, for those unable to communicate verbally.
In Holland there is a diversity of means of communication and appliances for people with a restriction, in order to live as independently as possible. Here is a survey of means of communication and appliances:

Frans was not always understood
by his parents, and as a result he became permanently dependent on them. However, he was very well able to say what he wanted to do or what he needed. To make himself audibly clear, they decided to the application of a speech computer for Frans, made on his wheelchair. Moreover Frans has a pictoagenda, so he knows what is going to happen this week. He does not always go to his parents and ask them.

For blind people:
- Portable computer with reading line in Braille
- Audible versions of books

For partially sighted people:
- Portable computer with text magnification
- Extra screen magnifier

For people with a physical restriction:
- adapted computer

For bad-hearing or deaf people:
- hearingaids
- sign language, also for people with a mental restriction
  Sign language is not universal. Deaf people in the entire world use sign language. Similar with spoken language, there is not ONE sign language, used by everybody. Every country has its own sign language, such as Dutch, Flemish, French, British, American sign language.
- Telephone adaptations
  - Separate telephone amplifiers, amplifying the sound from the receiver
  - Adapted telephones with built-in amplifier
  - Text phone
- doorbell amplifier
- warning systems for telephone or doorbell (flashing lamp or thriller).
- Thrilling or flashing alarm-clock

For people with speech-language defects

- Easy Talk is a small and handy appliance with many possibilities. 8 levels with a limit of 320 messages available.

- Wizard Colour is particularly invented for wheel chair users. With 80 minutes of recorded speech, up to 144 spaces per screen and up to 80 screens, thousands of messages can be communicated.

- My-Voice Touchy

- picture telephone

Pictograms

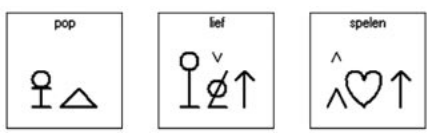
A pictogram is a symbol in the form of a picture, indicating a notion. For example, with pictograms you are able to make clear a client's daily program

Some different sorts of pictograms

"Visitaal"- Pictograms.
With a black background and a white picture

gestures *care plan* *group*

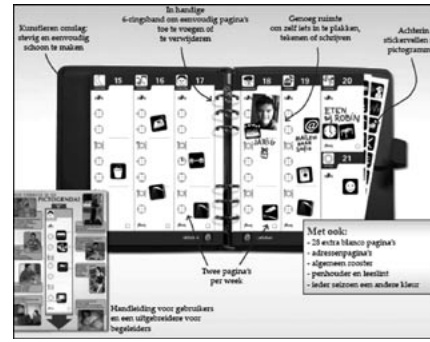
Bliss is a graphical language, used all over the world by people, unable to speak or write.



"*Gebarenblik*" is software for learning and exercising response gestures, which are gestures particularly invented or adapted in favour of mentally disabled deaf people.

The *Pictoagenda* is an agenda with pictograms, for children and adults with problems in reading, writing, and/or speaking.

- It is frequently used by:
- people with a mental restriction
- people with a defect in the autistic spectre



- people with speech and language problems
- deaf and bad-hearing people
- children from special education

4.6 Supporting Client's Network

Supporting clients in society also implies: assistance in building-up a social network. Counselling in network development means: supporting a disabled person in getting and maintaining contacts with other people in society. This not only concerns informal contacts with neighbourhood or sports club, but also formal contacts, such as with dentist or doctor. These contacts as well have to run appropriately. In network development, the starting point is that social contacts are an essential interest for every human being. Social contacts are part of one's identity.

Focused seeing to the clients' network is getting more and more important in the care for disabled people, particularly

when clients live outside an institute. As a counsellor, seeing to network development in a goal-orientated way is the best thing. as well as working methodically. You can make the following steps together with the client

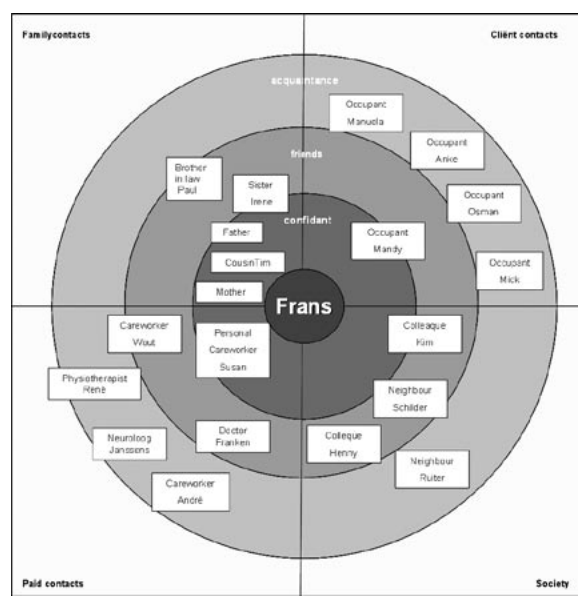
- Make and interpret a network picture
- Think about possibilities and extension of the network
- You make an action plan; with the client you make a list of his/her wishes. You also describe the client's and the counsellor's role. The best thing is to make the network picture and the report in understandable language for the client. This can be supported by pictograms
- Execute the action plan
- Evaluation of plan and approach

Approach for making a network picture

1. Make a list of names of persons, contacted by the client last year and with whom contacts were continued. When the client mentions too many names, such as names of people he/she in fact hardly knows, ask him/her to mention the most important ones. Of course you can help the client if a name does not occur.
2. Make a subdivision with four kinds of contacts
   - *Clients contacts* such as with other clients or with unpaid persons in the care circuit
   - *Family contacts*, contacts with people having a serious relationship
   - *Paid contacts* like with counsellors, doctor, dentist, and other people who get in touch with the client.
   - *Society contacts with people* outside the care circuit unknown to the client, like neighbours, friends, etcetera

   If the client is not able to read, of course you can also use passport photographs
3. Order the contacts in a network picture. Draw 4 circles and put the client in the centre. The first zone is *intimacy*, the second one is *friendship*, and the third one is *acquaintances*. Divide the picture in four spaces (four kinds of contacts)

Example of a network picture from Frans



5. Legislation

Since Frans' birth
a lot has changed in legislation. Since 1990 many new laws came instead of the ones becoming out of date. The new laws imply that Frans is allowed to make choices and decisions himself.

◆ These are the laws of most importance for disabled people

"*WGBO* Wet Geneeskundige Behandeling Overeenkomst" (Law Medical Treatment Agreement). This law determines the liability of the relief worker to inform the patient or client about nature and target of treatments. It also determines the client's necessary permission for treatments, as well as his/her right to inspect the nursing or care file. All this is to guarantee the client's legal position.
BOPZ wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen. (Law Particular Admissions in Psychiatric Hospitals). This law determines the legal protection from compulsory hospitalisation of patients. Within the care for disabled people you have to deal with it when means of coercion and freedom-restricting measures are used. For example: isolation, separation, fixation, and compulsory appliance of liquid, food and medication.
WKCZ: Wet Klachtenrecht Cliënten Zorgsector (Law Clients' right of Complaint Care Sector) Institutions in the care for disabled people are committed to make an arrangement for the treatment of clients' complaints.

5.1 Receivership, Administration, or Tutorship

◆ For people, not (entirely) able to take care of themselves. For example: mentally disabled people (sometimes

Already for years Frans' father
takes care for his son's finances, who is not able to do so himself. Even final decisions about nursing, treatment and counselling are the responsibility of his father. He is allowed to say if he agrees, but finally his father decides. The father is Frans' curator. This is not obvious, on the contrary there is a lot to do!

from their birth), psychiatric patients, Alzheimer patients or addicted people. These measures are mainly meant to protect against others abusing the situation and can only be applied with people of age. Until the age of 18, parents or guardian take care of minors' interests. Already then, measures can be requested. And they will be utomatically applied from the moment adulthood begins.

Receivership Meant for people who are no longer able to manage their personal and financial affairs. The law concerns "people of age with a mental defect who are (at intervals) hindered or unable to manage appropriately their affairs". Further, as reasons for receivership, the law mentions waste and alcohol abuse as a habit. In that case alcohol abuse has to lead to inappropriate management of affairs, repeated offensive or security endangering behaviour in public. When being in receivership, one loses legal competence, so is not allowed to perform legal acts independently. Someone being in receivership is called **person under legal restraint**.

Administration of goods is meant for people who are, for the time being or lasting, not able to manage their financial affairs because of their physical or mental situation. It is not always necessary to administer ALL goods of a person. Sometimes the administration of some few goods is sufficient. In that case the concerned goods must be exactly indicated in the request. When a person's goods are administered, entirely or partially, this person is not allowed anymore to decide independently on them. He/she for example is not allowed to sell anything without the administrator's permission. Decisions however, as long as possible, have to be taken together with the person in question. The administrator also deals with the administration of the goods. In managing a person's financial affairs the administrator is also allowed to do someone's tax declaration and apply for (supplementary) benefit or housing benefit.

Tutorship Is meant for people who are not able anymore to manage their personal affairs (**not** concerning money or goods). It concerns mentally disabled people or psychiatric or comatose patients. But also aged people, such as elderly demented who are not able anymore to take decisions on personal level. Mainly they are decisions on care, nursing, treatment, or counselling. Then, as much as possible together with the person in question, the tutor takes the decision. For example concerning medical treatment, when someone has to choose between living dependently or independently.

5.2 Summarising the Measures

	Receivership	Administration	Tutorship
Measure	A person looses legal competency, so is not allowed anymore to perform legal acts independently. A receiver is appointed to represent the person under legal restraint. By being in receivership person and property are protected.	A person is not allowed anymore to decide on goods under administration An administrator is appointed to decide on them (as much as possible together with the concerned). Administration protects the person's property.	A person is not allowed anymore to decide on care, nursing, and treatment A tutor is appointed to decide on them (as much as possible together with the concerned). Tutorship protects the person on personal level
Tasks	The receiver manages the financial and other affairs of the person under legal restraint.	The administrator manages the person's financial affairs.	The tutor decides on care, nursing, treatment and counselling of the concerned
Are appointed	Receiver Appointment of legal person not allowed	One or more administrators Appointment of a legal person allowed	A tutor Appointment of a legal person not allowed
Procedure	Request in court by a lawyer	Request in court, sectoral or cantonal (no lawyer needed)	Request in court, sectoral or cantonal (no lawyer needed)
Publication	Publication in Gazette and two national daily newspapers Receivership register	Registration in goods register.	No publication
Termination	In court - If someone is able to manage personal affairs again - Substitution by Administration and/or Tutorship - In case of decease	By cantonal judge - If someone is able to manage personal affairs again - Substitution by receivership in court - When the period determined by the judge is expired - In case of decease	By cantonal judge - If someone is again able to manage personal affairs - Substitution by receivership in court - When the period determined by the judge has ended - In case of decease

[2]

[2] Curatele, bewind en mentorschap (Receivership, Administration and Tutorship)
Edition Ministerie van Justitie. Reprinted June 2006

6. Financial Support

In the meanwhile Frans has grown up
to be an adult man. Just as his sister he likes to live on his own. His parents are going to find out how this can be financed.

◆ In The Netherlands there are a number of laws, making that people with a restriction are financially independent. The following laws help people financially on different levels.

Wajong; Wet arbeidsongeschikthei dsvoorziening jonggehandicapten; (Disablement Insurance Act Young Disabled People). For people with inability to work already at the age of 17, or when studying. A Waging benefit can be continued until the age of 65, so it is not only for disabled young people. If you get disabled during your youth, you never had the opportunity to do a paid job. Therefore, when unable to work, you are not entitled to a payment which is linked to that paid job, such as with the =disablement act. In that case the "Wajong" Law is a safety net on minimum level.

AWBZ; AWBZ (General Law Particular Medical Expenses) is a social insurance for medical expenses risks, which are individually uninsurable. Every inhabitant or employee in Holland is insured and entitled to compensation from AWBZ-care. The AWBZ covers heavy medical risks, which are not covered by Medicare. It concerns medical expenses that hardly anybody can afford. Medical insurers from special care offices execute the AWBZ. AWBZ compensates for particular medical expenses, such as long-lasting care at home, or hospitalisation in a nursing home or in an institute for disabled people. Medicare does not compensate for these costs. In the course of 2007 institutes will have to deal with many changes in the AWBZ, because of the introduction of the law "Wmo" (see below).

PGB; A "Persoons Gebonden Budget" (personal budget) is an amount of money someone receives to buy his/her own care. Wit this money people choose a relief worker themselves. With a personal budget someone is able to buy care, deciding personally when and how care will be given. One can also choose for care in kind, or for a combination of personal budget and care in kind. Anyone needing care because of disease, handicap or old age, can choose for a personal budget. With a personal budget you can buy 'care functions',

namely personal care, nursing, activating/supportive counselling, and temporarily accommodation. (staying over). The right to this care is fixed in the Law Particular Medical Expenses (AWBZ). Personal budget is not possible with treatment and long-lasting stay. That care is always delivered in kind. Also domestic care can be bought with a personal budget.

Care in kind is direct care, delivered by institutes.

Wmo; the aim of the "Wet Maatschappelijke Ondersteuning" (Law Social Support, since 1st of January 2007) is to let everybody participate in society.

- It arranges support (from their municipality) for people who need assistance in daily life. This concerns services like help with the housekeeping, a wheel chair, or adaptation of residence.
- It supports people who are engaged with fellow human beings or neighbourhood. For example volunteers or volunteer aids.
- It stimulates activities that enlarge engagement with neighbourhoods and quarters.
- It offers support, preventing that people will need more serious kinds of assistance later on. It concerns for example support in education and activities against solitude.

People can address themselves to their municipality for all kinds of support that enable a normal daily life, for example a stair lift if someone is a bad walker.

The municipality considers what is the best support for the questioner. Each municipality arranges things in its own way.

7. Services for Disabled People

7.1 Introduction

◆ It is a description in two separate chapters, because in Holland there are many provisions, for mentally and physically disabled people. In chapter 5.3 we will focus on physically disabled people's provisions. In chapter 5.4 we will focus on mentally disabled people's provisions.

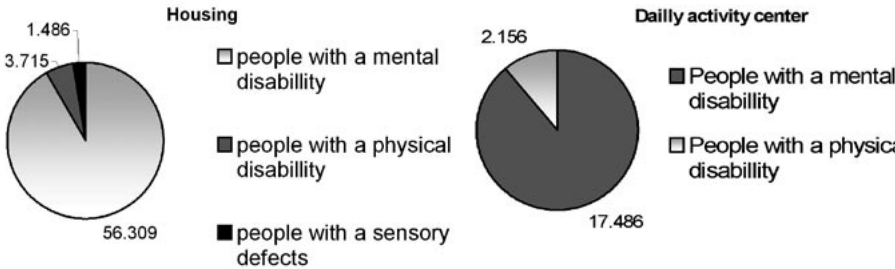
When Frans was 1 year old,
it was clear that he had an intellectual restriction. His parents are in contact with the MEE organisation. With Frans' parents they have considered Frans' needs and where to get aid. In cooperation with this organisation they also found leisure activities for Frans.

7.2 MEE

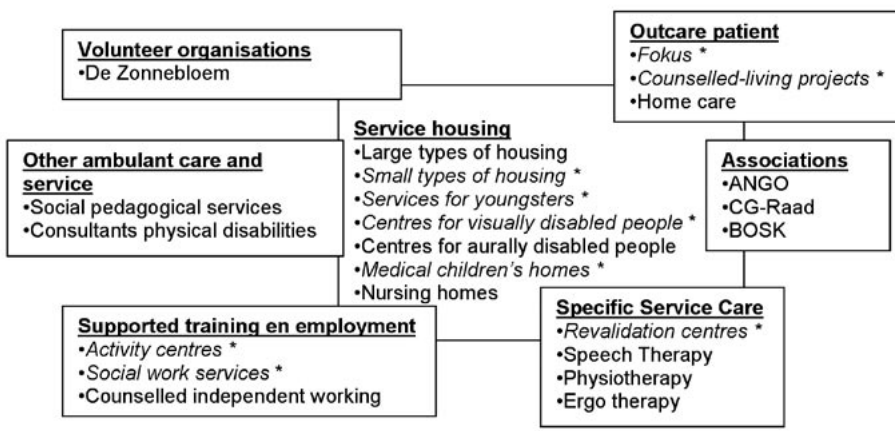
◆ MEE is an organisation, answering to questions from people with a handicap, a chronic disease, or function restriction. MEE gives information, advice, and support to mentally or physically disabled people (young and old), but also to others that experience restrictions in their lives, such as people with a hearing problem, a visual handicap, or autism. MEE supports them in many fields of daily life. Within MEE professional people can help with questions concerning education, upbringing, living, working, social services, income, transport, leisure, juridical affairs. MEE informs, helps with difficult decisions and, if necessary, shows the way to the appropriate authorities.

MEE is there for people who, because of their disabilities, experience problems in their daily lives, so they are not completely able to participate in society. MEE is there for young and old, for the most concerned, but also for parents or caretakers. MEE does not depend on care providers and other authorities, so it is only focused on the clients' interest. The government pays MEE's services, so they are free for the most concerned, and for parents and caretakers. To be entitled to support by MEE, no reference or indication is needed.

7.3 Survey of Services between Physical and Mentally Disabled People



7.4 Services for People with a Physical Disability



** Place possible for work placement*

Specific Service Care
Rehabilitation centres; here clients receive a multi-disciplinary rehabilitation treatment. Mostly it concerns people with a physical disability. The treatment is aiming at getting a place in society as normal as possible.

Outpatient care
Fokus - projects; are adapted, independent, rented houses for people with a serious physical disability. Residents can make use of a central aid-post, for 24 hours help in and around the house

Counselled-living projects; Entirely or partially dependant house, for people not (yet) able to live on their own. Clients do live as independently as possible. Counsellors are only present on demand, with a limit of a few hours per week, focused on practical affairs like dealing with money, cooking, cleaning. Some projects are meant for people with a physical disability.

Housing services

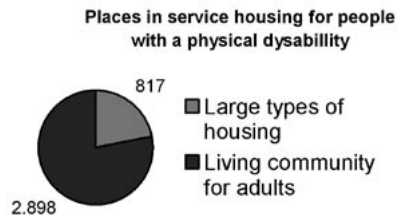
Small types of housing; in the Netherlands there are about 55 small types of housing. They are "surrogate family homes' for physically disabled people, living rather independently. The target of this type of housing is to stimulate integration in society, by stimulating (social) ability to live.

Services for youngsters; offer a surrogate home to physically disabled youngsters. Aiming at youngsters' development in many areas, such as relationship and society

Centres for visually disabled people; offer care, and service to blind, partially sighted, or visually and mentally disabled people. Care and service are various and depend on the clients' group aimed at, or on clients' individual demand for care.

Centres for aurally disabled people; for bad-hearing or deaf people, possibly with a mental disability.

Medical children's homes; institutes for medical observation, treatment, nursing and care for children with serious physical and/or mental problems. They cannot be sufficiently helped at home or at the outpatients' clinic. Residents are not older than 16 years.



Supported training en employment

Activity centres; have a large offer of activities, multidisciplinary counselling, talk groups, and courses. They aim at personal evolution and meaningful occupation, working on development and maintenance of social, cognitive, emotional and motor skills.

Social work services; for people with physical and mental disabilities, and people placed on the base of social indication, such as ex-psychiatric patients. People are expected to do normal work in an adapted way, offering them a protected work place.

Associations for physical disabled people

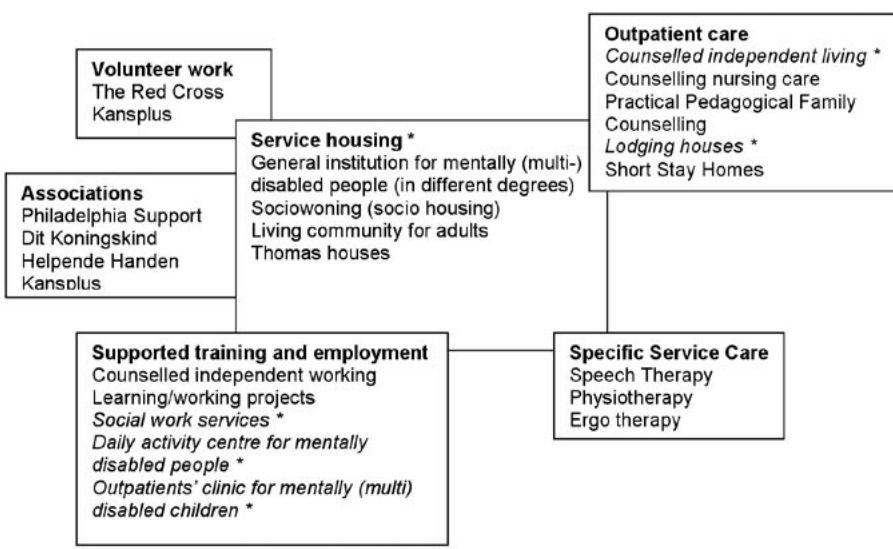
For people with a physical restriction there is no parents' association, but there are different organisations, labouring in various ways for their target group.

ANGO National organisation of, for, and through people with a functional restriction. Information, advice, and protection of interests, starting from the practical experience by members. Is the result of three previous organizations. ANGO is an organized interest group by and through people with a physical restriction, chronically sick patients and people unable to work. ANGO gives information and advice, contacts between fellow-sufferers and financial support.

Chronisch Zieken en Gehandicapten Raad Nederland (CG-Raad) The Dutch Board for Chronically Diseased and Disabled People. Umbrella of organisations of people with a chronic disease or a disability. Defends valuable citizenship for disabled people/chronically sick patients, based on equal rights and opportunities. The members are organisations and platforms for disabled people; you cannot become a member as an individual. The CG-Raad protects the interests of these organisations. Another task is the provision of services like means, education, or labour.

BOSK *Gives* information and advice, realizes contacts between fellow-sufferers and protects interests of disabled people.

7.5 Services for People with a Mental Disability



** Place possible for work placement*

Frans' indication is arranged.
So his parents are looking for suitable housing. They discovered many possibilities for both living and daily activities. What is wisdom!

Volunteer work
The Red Cross has become the symbol of help to people in need. It works with volunteers. Its work is very diverse. There is for example a home for diseased children, transport for people in wheel chairs, teaching for minor asylum seekers to cook, visiting lonely aged people, medical assistance at events and disasters. It observes where help is best needed, consults help questioners, and offers concrete solutions. Whenever possible, help is offered.

Kansplus association for mentally restricted people and their relatives. It is a national association with several units. Activities differ in each unit.

Outpatient care
Counselled independent living For slightly disabled people. Residents are counselled 2 till 4 hours a week for example with managing money affairs, cooking, or keeping contacts. They must be able to take care of themselves and their houses, and to resolve small problems in daily life. They often have a job by day, for example in a social workplace. Counselling is arranged from an MEE, surrogate family home, or another institution. They stimulate clients to take own initiative and decisions. Parents/caretakers take care for housing, for example with the help of housing associations. This type of housing is financed by AWBZ.

Lodging houses mentally disabled children or adults, normally living at home, can stay there for a week or a weekend. By day they go to school or to their daily activity.

KVT (Short Stay Homes); If temporarily not being able to take care of a disabled family member, for example because of disease or holiday, a family can make use of a KVT. The maximal continuous 24 hours stay in a KVT is one year. Sometimes it serves as a transition period towards permanent placement in another institute.

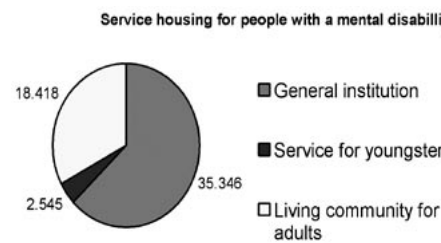
Types of housing
General institution for mentally (multi-) disabled people (in different degrees); besides treatment and counselling, people receive 24 hours care. Each group (variable in number of persons) is supported by permanent counsellors.
- Length of stay is unlimited.
- By day some residents follow education or work in a social work service.

- Besides group leaders there are for example: doctors, physiotherapists, psychologists, psychiatrists and activity counsellors.
- Many institutes have a parents/family council
- There are specialized institutes, orientated towards people with autism or epilepsy.
- An indication is needed from the "Centrum Indicatiestelling Zorg" (Centre for Care Indication)

Sociowoning (socio housing) is a house with10 to 20 residents, belonging to an institute for mentally disabled people. It is a copy of a 'normal family situation': residents have liberties, responsibilities, and develop independence. In a socio house clients are more independent than in an institute for mentally disabled people. Most of them follow a programme for daily activities or work in a social work service. They receive 24 hours care.

Living community for adults18+ (Gezinsvervangende tehuizen = GVT) who are able to operate rather independently. They are supported by a permanent group of counsellors. They do activities, follow special education or participate in a work service. Mostly a GVT is situated in a common residential quarter. Sometimes there are separate locations for people who need little counselling. 3 to 6 people live in such an "annex". Often it is a step towards counselled independent living. There are living community for children of 2,5 to 18 years old. Sometimes also multi-disabled children are welcome there. Residents receive 24 –hours care.

Thomas houses These are small-scale living services for 6 to 8 people with a mental restriction. In general two caretakers, mostly couples/partners, guide each house. They are ultimately responsible for their clients' care and support. A Thomas house is an independent undertaking. Caretakers have to live in the house or next to it. The essence of the entrepreneurship is a personal interpretation of care.



Supported training and employment

Social work services; only for people unable to do ordinary jobs because of physical, psychic and/or mental restrictions. Work is really work here, adapted to a worker's possibilities. You work with colleagues and get salary. There are various possible adaptations: schedule, work place and speed. There is also support by a counsellor. Working in this way is not obligatory, not even with a benefit. So personal motivation is important. It is possible to work on a fixed number of days in the week.

Daily activity centre for mentally disabled people; for mentally (multi-) disabled people, unable to work. It is called a daily activity centre, but not only meant to keep visitors busy. Activities depend on what people can do or want. Much time is spent to find out. If for example someone would like to work in an enterprise, assistants will create possibilities, even when having personal doubts. Labour and handicraft activities can be done in a daily activity centre, but also in society: gifts' shop, copy shop, studio, packaging, (nursery) gardening, lunchroom etc.

Outpatients' clinic for mentally (multi-) disabled children between 2-17 years old. Orientated towards maintaining and stimulating children's social ability and integration in society. Each client has an individual treatment plan. Also children's family and environment are well informed and -counselled.

Associations for mentally disabled people

Parents' associations protect the interests of mentally disabled people, their parents, and other relatives. They played an important role, and still do, in realising modernizations.

We have the following parents' associations

- *Philadelphia Support* Christian association for parents of mentally disabled people, their family and friends
- *Dit Koningskind* Association of Reformed people with a disability, their parents and friends.
- *Helpende Handen* Association Care for Disabled People of the Reformed Communities
- *Kansplus* Association for parents and relatives of mentally disabled people.

8. Working in Different Care Settings

Frans is sitting at the table
and has nearly finished dinner. The group ends with having a dessert. For Susan, the care-worker, it is important that clients make their own choices, even if there are only few. Susan asks Frans which flavour of dessert he wants, strawberry or banana. He points to strawberry, because he is fond of it. You can see he enjoys it very much.

Frans goes away with his mother for one day. What does he want to wear? Brown or sporty socks? He choses the sporty ones. Susan gives him only two options, because with more options making a choice is too difficult for him.

Making one's own choices provides more self-confidence and independency. Who doesn't want so???

8.1 Ethical Codes / Standards

Professional code:
In The Netherlands we have a professional code for care workers level 3-4 and 5.
This professional code consits of 4 parts:

- *As a professional:* make no distinction between people, have a sight on your own (im)possibilities, take your responsibilities, keep your motivation
- *Postion towards the client:* focus attention on self-determination, privacy, no making sexual advances by one self or by the client, no aggressive approach, respect for norms and values.
- *Operating from a care institute or aid organisation:* tackle colleagues in case of not fulfilling the code, contribute to policy development, cooperate and negotiate with colleagues, support colleagues in case of trouble because of fulfilling the code, take care for optimal conditions to enable cooperation and negotiation with colleagues
- *Working on professionalism:* speak positively about profession and professional group, observe developments in society, receive (re)training, support and participate in activities creating conditions for professionalisation and quality improvement, take care for labour conditions contributing to an optimal professional performance

Professional attitude:
Professional attitude is the way you behave in the performance of your profession and in the relationship with the clients. How you are as a person with all your qualities is very important in working with disabled people.
You have to be

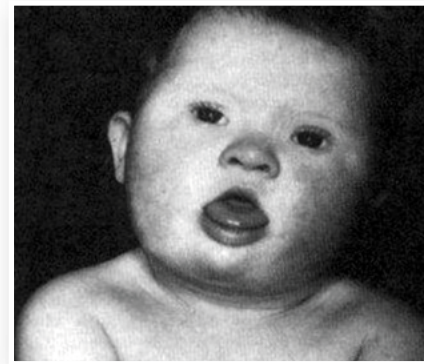
- Involved
- Empathic
- Assertive
- Representative
- Incorruptable

Frans depends on the care-worker. He has to leave a lot of things to others, but on the other hand he is very well able to make many choices himself. The care-worker has to be aware of that.

8.2 Practical Examples

◆ In the Netherlands there are many types of services for people with disabilities. Here are 3 different practical situations from 3 different working areas, describing (daily) activities of three persons called Cor, John and Petra.

First practical example Cor works in a social-therapeutic living and working community for mentally restricted people. The basis is anthroposophy. Everybody is considered to be a spiritual being, with individuality and personal development. Individuality is eternal. Linked to the physical body, the spiritual being can develop in respective



lives on earth. In this concept, spirit and individuality are always sane. People with physical and development defects have a disturbed relationship between individuality and body. So processes like thinking, feeling, willing can be strongly influenced.

Second practical example John works as an activity counsellor at an activity centre for physically disabled and/or multi-disabled people or people with non-congenital brain damage.

Third practical example Petra works as a client counsellor at a living community for mentally disabled people. Here people receive 24 hours care. There are early, late, and night services. In this practical example a late service is described, because then most people are there. By day most people do daily activities.

8.3 A Day in the Working Life of Cor

◆ *Cor works as a living and working counsellor in a social-therapeutic living and working community for people with a mental restriction and/or autism*

Morning service starts early. She is present before 7.30 and together with residents who have duty. She makes breakfast (with coffee, tea, bread, etc.) so at 7.45 they can all have it in the large room. Cor says grace and they start eating. This is the most complicated meal, because many residents are not yet completely waken up, so they are irritable. At the same time he has to tackle latecomers and take care of a good atmosphere, so that residents can start their day in a good mood. Martin is in a bad humour and provokes other residents. They do not accept and Cor asks him to take care of himself, so the others can eat quietly. Having no result, Cor proposes him to leave the room and eat in the afternoon, but now he no longer interferes. Hans and Pieter must finish breakfast in time because a taxi gets them at 8.

Around 8.10 the residents leave the table. Cor distributes morning medication and must be aware that some residents are not going to take it at the office. These residents will be picked up. In the meantime trainees, day nursery clients, and day service colleagues arrive. At 8.30 all residents come together in a circle in the living room. Cor says a morning prayer to open the day. Then everybody can bring in a positive message, after which working scheme and therapy program for the day are read loudly.

Daily work is done in different work and task areas, namely: animal care, forestry, woodwork, gardening, pottery, plaiting, textile, and housekeeping. All residents have a daily task in an area. The work is done at fixed times between 8.30 - 17. Breaking moments are: Coffee break 10.15-10.45 lunch break 12.15-13.30 and tea break15.15-15.45.

With 4-5 residents Cor goes to the plaiting work place. She helps the residents with plaiting their mat. Or they choose a pattern and colours for plaiting a new one. The residents work individually on their mat. Cor supports them if necessary and corrects mistakes. Pieter often needs Cor's control; he hears voices in his head, so he is badly concentrated. Hereby he makes many mistakes, so he often has to pull out pieces of is work. To break this through, Cor involves him in conversations and asks him to help others with finishing a mat. Geert has an autistic defect. He does not make direct contact. When he starts walking around or cleaning up things, Cor knows that he needs help. Patty is not eager to work anymore; she just wants to leave. She easily gets angry and abreacts. Cor tells her that her presence is agreeable, because se

can be so nice and she is good at her work. So Cor tries to influence her mood positively. But she has to do this more than once a day, by making compliments. When having finished her mat at the end of the day she is satisfied, which was Cor's target. They have lunch together. At his table Cor watches the residents' table manners, atmosphere, and eating manners, for example Toon because of his diabetics. Cor also watches if the food they take is wholesome, such as meat and cheese. An easy atmosphere is also important. After lunch Cor distributes the afternoon medication and joins others, talking and smoking a cigarette outside.

At 13.30 work in the different areas is restarted. So they go back to the plaiting workplace until tea break at 15.15.

After that they work shortly and clean up together. Cor and the residents finish the working day. Cor thanks the residents for their presence and checks if they liked it all. He works with them until16.00, then his working day is finished. A colleague sees to cleaning and closing the work place.

8.4 A Day in the Working Life of John

◆ *John works as an activity counsellor at an activity centre for physically (and/or multi-) disabled adults or adults with no congenital brain damage.*

The working day starts at 8.30 with coffee and briefing. During the briefing the day is walked through. Today 8 activity counsellors work on 4 different activities: computer, cooking, work place, and swimming.

Care plan discussions start at 8.45, where clients are discussed once a year. Today it is Mr.Janssen's turn. The discussions concern all his activities in the year gone by. All colleagues present today participate in this discussion to get an optimal image of Mr. Jansen and to fix targets for the year coming.

At 9.30 the clients arrive. A colleague made coffee and tea. Today John goes swimming with 8 clients. However, the swimming pool is at the other side of the town. Clients are taken there with a van. Together with Marian and a volunteer, John helps the clients to undress. Some are able to walk; some take a "shower wheel chair" to the swimming pool. Mrs. Suikerbuik is not able to take the stairs into the swimming pool, so she takes the elevator.

John helps Mr. Franken, who is exercising to swim on his back. He gives him instructions for a better floating. Other clients swim to improve their condition. The last 10 minutes of the swimming, clients move on music. John gives them exercises with music, to improve their forces and condition. Everybody gets dressed again, some clients need all hep, and some only

need it with fixing their shoes. John drives the van back to the activity centre. Clients in a wheel chair have to be fixed in the van.
John and Marian are back around 11.30 and have coffee. Other clients had coffee at 11.
At 12 all clients have lunch together. John and 3 colleagues are seated to help clients, unable to eat independently. The other colleagues have lunch break. John and his 3 colleagues have it, when the clients are ready.

At 13.30 afternoon activities start. John leads a computer activity with Henk, his colleague. There are 10 different clients with very different questions. Some are learning Word, others Excel. Some prefer to play games on internet.
John helps mr. Pieterse with learning Word. At the same mrs. de Vries has a question about Excel, another computer breaks down.
At 14.30 they have coffee in the activity room. Henk stays with the group and John helps them to the toilet. Then they restart.

At 15.45 activities are stopped. All colleagues help the clients with putting on their coats to go home. John arranges the washing-up and closes doors and windows. Then there is still time for preparing next day's activity. Tomorrow John has a sports activity with 11 clients.

At 17.00 all activities are finished. John and his colleagues go home.

8.5 A Day in the Working Life of Petra

◆ *Petra is a housing counsellor at an institute for mentally disabled people*

Late shift.
14.45 - 15.50 Petra's late service starts at 14.45. An early service colleague hands over the mission, with all particularities. They have coffee and discuss/arrange additional affairs.

15.50 - 16.00 Petra makes orangeade for the clients. At 15.50 the first one returns from the daily activity. They talk; she gives her the orangeade and a cigarette. She is often bad-tempered at this moment and takes a rest in her room from 16.00 till 16.30. But sometimes she gets wild, cursing and scolding and sometimes throwing cups, chairs and ashtrays in her neighbourhood. Petra tries to clear up the place, just before 16.00. If things go wrong, he accompanies her to her room, talking to her. He locks her room to come to rest.

16.00 - 17.30 All clients come home from daily activity and have an orangeade. Mr. Kop receives medication. Petra talks and has time to listen to clients. At 16.30 clients do something for themselves. Petra reads and answers his mailbox, focusing on particularities. At 16.45 she puts the food in the oven and at 17.00 he asks

Mr. Franken to lay the table (partly counselled, partly independently). At the same time, if Mrs. de Vet as escalated, he sees to it how se does, possibly to come down. They have a short talk about it. If she calmed down, she can come downstairs. If not, her room remains locked and she will have her dinner afterwards.

17.30 - 18.30 At 17.30 they have dinner. Petra calls every client and dishes up for each of tem. She does so, because they would dish up too quickly and without measure. She counsels the clients as she did at breakfast and lunch. Some clients get medication with their dessert. After dinner each client cleans up his/her own things, and Petra does the rest. Mr Konings swills the dishes and puts them in the dishwasher. Petra helps him with some coaching, if necessary. For the rest of the evening clients are free to do something fore themselves. If Mrs. de Vet is still in her room, John takes a look at 18.00. Then she often has calmed down, and can have her dinner downstairs after a talk.

18.30 - 19.30 Time for bathing. Once in two days it is Mr. Verbocht' s turn. Petra counsels him, coaching how to wash himself. He has got a special washing lotion for his sensible skin. Petra sees to it that he washes away the soap rests off his body and that he wipes his body appropriately dry. Then he can pt on is pyjamas. Mrs. Oerlemans is going to put on her pyjamas. Petra helps her with undoing buttons and shoelaces. She lays out her clothes for the next day. Petra takes a walk in the quarter with Mr. van Steen, who then has the opportunity to talk without being disturbed; it relieves him. Petra listens to his story and reacts. After the walk Petra makes two pots of coffee.

19.30 - 20.00 Petra takes coffee together with the clients. They watch the news and chat. In the meantime Petra sees to it, that Mr. Broeren puts his watch on the cupboard, to avoid spilling coffee. Each client gets two cups, which most of them can pour themselves.

20.00 - 20.45 Petra cleans up the coffee cups and Mr. Konings does so with the dishwasher. The next day some clients will be picked up early for daily activities, so they already make sandwiches. Petra sees to it, that they take the right filling and not too much, because of their diet. She puts glasses ready for a drink. Mrs de Vet lays the table for the next day.

20.45 - 21.00 Clients can pour their own soft drink. Mrs. Oerlemans gets medication. Petra joins them, chatting and drinking.

21.00 - 22.00 After drinking, Petra asks the clients to already put on their pyjamas. Mrs. Oerlemans is going to brush her teeth and wash her hands. Mr. Broeren takes a shower every evening after Petra's instruction. She undresses and washes himself independently, except his hair and back.

Mrs. de Vet is going to bed. For the next day Petra puts ready new clothes with her. She cleans her set of teeth, putting it in a glass of water with a cleaning product. They have a small talk about the day and he wishes her goodnight. If she wants, she can still watch TV or listen to some music. Her door will be locked; she can get out, but other clients cannot come in.
If necessary like in the morning, Petra oils Mr. Verbocht, lays ready clothes for the next day wit him, and wishes him goodnight.
Then she puts Mrs. Oerlemans on the toilet and climbs the stairs with Mr. De Lang so in front of him, because he has a tendency to take more stairs at a time, pulling himself up at the handrail. Petra brushes his teeth and puts his clothes ready. He can still watch TV or listen to music if he wants to. Then Petra wishes him goodnight.
Petra goes downstairs to put Mrs. Oerlemans in her bed. In front of the toilet Petra helps her to stand on a special appliance. She rolls it in front of her bed and makes her sit down. She turns her into the right position and lifts the bed, for changing her nappy and putting a cushion under the back of her knees. Her night things must suit for a good sleep. Ten she lifts the bed rail, puts the bed down and wishes her good night.
Mr. Konings brushes his (set of) teeth independently. Together with Petra she puts new clothes ready and goes to bed.
Not later than 21.30 Mr. van Steen has to be in is room, brushes his teeth and goes to bed. Then Petra goes to Mr. De Lang, tells him to brush his teeth and puts his clothes ready.
He lays down in his bed and they talk. He will be rewarded financially if he sleeps well. After having a certain amount, he can buy something in a shop. Petra wishes him goodnight and locks his door, which can be opened by Mr. De Lang if necessary.
Petra pulls on a cord in the entrance, to make it dark. Otherwise Mr. Kop will start playing with his dinky toys, without sleeping the whole night. In the meantime Mr. Broeren has taken his shower and brushed his teeth. He goes immediately to his room, where John puts his clothes ready. Mr. Broeren likes watching TV for a short while.
With everybody in his/her room, Petra locks the bathroom door and the stair gate.

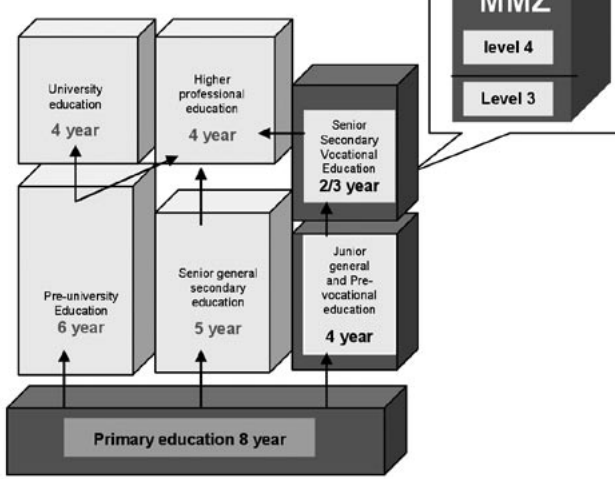
22.00 - 22.45 Petra reports the particularities of this evening. He does so in the report file and on the computer, in Care view. Then she writes things in the notebook, relevant for the night service.
Then she fills the washing machine for the night and turns on the dishwasher. She charges Mrs. Oerlemans wheel chair and puts cigarettes ready.
He locks doors if necessary, and goes to his neighbour colleague to discuss the evening and to take his night notebook. She puts on the night alarm and goes to the night service, to hand over the care and its particularities. Petra's service ends at 22.45.

9. Vocational Education

Irma is a care-worker in Frans' group.
She is 18 years old and recently took her certificate level 3. She is a starting professional and will have a lot to learn. So sometimes she is still uncertain, is she doing alright? If she is in doubt, she consults a colleague who works with the neighbours.

9.1 Curriculum for Care Workers

◆ In The Netherlands, to become a professional worker in the care for disabled people, you have to receive training for Worker Social Care. In this training there are two levels, namely. Intermediate vocational education level 3 and 4. Below you see the classification. This training starts for the first time in the school year 2007-2008.



9.2 Competencies

◆ In the Netherlands, at the very moment of the writing of this booklet, there is a big turnaround in teaching. All trainings in the field of Senior Secondary Vocational Education and Higher Professional Education will have to teach in a competency-orientated way. In 2010 each training has to work in that way. This is a big operation. All books, methods and teaching activities have to be revised and updated.

Examples

Frans has an intermediate cerebral palsy and a mild mental deficiency. So Susan, the care-worker, must have knowledge about intermediate cerebral palsy and a mild mental deficiency. What does this imply and mean for Frans' possibilities? In her communication Susan has to gear to Frans' level, so: not using to difficult words, using short sentences, understanding his (non)verbal signals. She also has to be able to perform caring tasks.

Her behaviour has to be orientated to enlarging Frans' ability to do and choose things independently. What are Frans' possibilities?

Els has a mild mental deficiency and diabetes.

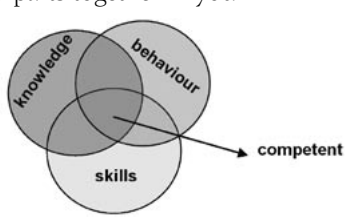
Knowledge: Susan has knowledge about diabetes, (kinds of) insulin, about what goes wrong in the body and which organs interfere, about the moment of medication and injection, etc.

Skills: Susan knows how, where, and when to inject insulin.

Behaviour: Susan shows to Els that she understands that Els is afraid of injecting and speaks to her encouragingly while doing so. Els also likes normal food and sweets. Susan takes care that she gets something with her coffee. She praises her when she keeps well to her diet.

A competency consists of knowledge, skills and behaviour.

You are only really competent if you bring the 3 parts together in your activities.



At this moment there are 25 competencies. Not all competences have to be obtained at for example level 3. Generally the competencies are valuable for all sorts of trainings (motor vehicles, ICT, hairdressers). All competences are supported by working processes, belonging to the work field. In this way they fit with the future profession. (See appendix)

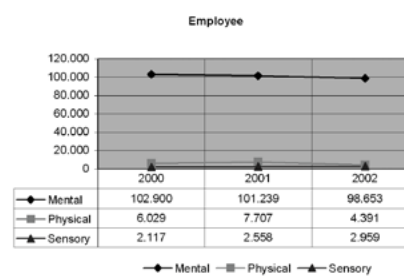
10. Employment Opportunities

Frans is counselled
by a team of 4 counsellors, namely Wout, André, Irma and Susan. Wout and Susan received a training on level 4. Irma level 3 and André level 3 care-workers. Wout and Susan are personal care-workers of all the clients in the house. André is good at caring aspects and supports the team in this.
Irma is responsible for the performance of the clients' care plans. Right after her certification she found a job for 24 hours per week. The remaining hours she has a flex-contract and she works at other places within the organisation.

10.1 Description of Employment

MBO (Intermediate Vocational Training) MMZ level 3
Function scale 30-35
The function of counsellor aims at looking after the performance of supporting people with a disability on individual and group level. On the basis of frameworks, indicated by the personal counsellor, the counsellor is co-responsible for the performance of the individual support of the client.

MBO (Intermediate Vocational Training) MMZ-level 4
Function scale 35-40
The function of counsellor aims at looking after the performance of the clients' care. The counsellor contributes to the realisation, performance and evaluation of the individual personal plans. Independently the counsellor carries out care-related tasks, within the frameworks of the individual personal plan. This concerns an independent function in a small team. Mainly, the counsellor's responsibility lays in the primary care, the client's daily care and nursing. Besides, the coun-



sellor also participates in the team supporting activities.

Qualification level	*Fte*	*Persons at work*
MMZ level 4	13.800	20.800
MMZ level 3	8.700	14.900

Fte stands for 36 working hours (2004)

10.2 Working Time

◆ If you work with people with a disability you have no job from 9.00 to 17.00. So many different clients! So many different care demands! So it is not possible to indicate which working hours there are. And also every organisation organises differently.
The new trend is that, by day, the clients are not on the place where they live. No clients no work! As a counsellor, you are active at the moments when the client is there. This means that you are present early in the morning and after the clients' working time. So there are early, late, sleeping and night shifts. Day shifts are decreasing.

Sleeping shifts: with these shifts you are sleeping by night at your workplace. Hereby you have to think of the following workplaces:
- Sociowoning (socio housing)
- Living community for adults
- Thomas houses

You get paid for half of your sleeping hours. The remaining hours are unpaid. In the morning your shift is finished. When a client becomes sick or gets an epileptic attack the care-worker comes out of his/her bed and looks after the client. When the situation lasts longer than 2 hours, the night is paid completely.

Generally, in institutions for people with disabilities, there are night-shifts. This is a special function and trainees will not be placed in such a function.

Vacation rights
The employee is entitled to a paid holiday with 166 vacation hours in a calendar-year. For part-time employees there is a regulation in proportion to the extent of the employment.

Salary scales	**Level 3**			**Level 4**	
Function scale 30		*Function scale 35*		*Function scale 40*		*Function scale 45*	
0[3]	€ 1505,-	0	€ 1587,-	0	€ 1686,-	0	€ 1913,-
1	€ 1587,-	1	€ 1686,-	1	€ 1800,-	1	€ 2018,-
2	€ 1686,-	2	€ 1800,-	2	€ 1913,-	2	€ 2127,-
3	€ 1743,-	3	€ 1853,-	3	€ 1961,-	3	€ 2182,-
4	€ 1800,-	4	€ 1913,-	4	€ 2018,-	4	€ 2237,-
5	€ 1853,-	5	€ 1961,-	5	€ 2072,-	5	€ 2293,-

[3] *This stands for function years. Each function year your salary raises, as indicated above*

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www.handicap.nl
Information about various things, such as work, education, respect, etc.

www.cg-raad.nl
The National Dutch Board for Chronically Diseased and Disabled People

www.MEE.nl
For information in English you can request a leaflet by the website.

www.mezzo.nl
National Dutch Association for Aid Volunteers and Care Volunteers. For more information about housing, work, finance, help and leisure. General information about Mezzo available in English.

www.ciz.nl
Centre for Care Indication

www.zonnebloem.nl
Information about the volunteers' organisation for people with a physical disability and elderly people.

www.kmd.nl
Information about communication appliances, serving computers and environment manoeuvring.

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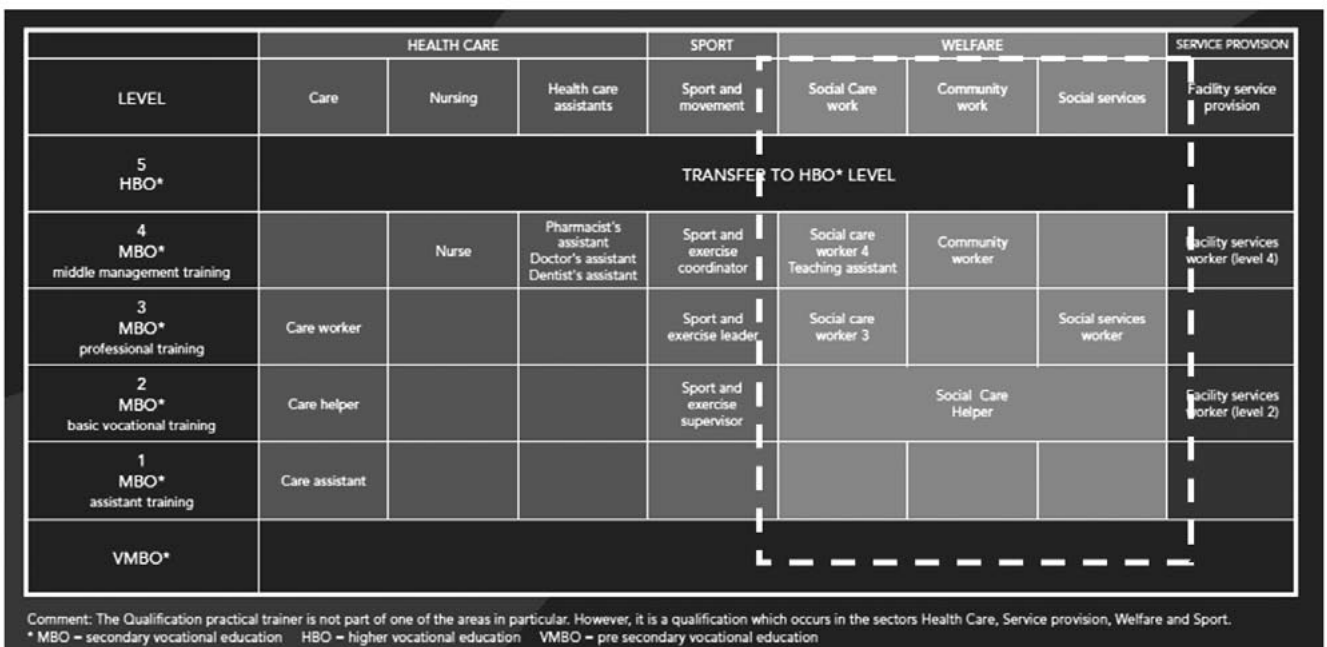
The National Association of the Care for Disabled People. Information about the Collective Labour Agreement

12. Glossary

Disability	A disability refers to a disorder or limitation that makes that someone is hindered in his/her normal functioning.
Integration	Incorporate in a whole
Valuable citizenship	The disabled person is considered to be a valuable citizen.
Ethics	Practical philosophy occupied with good and evil.
Clients Board	Clients, parents or legal representatives with an advising role within an institute. Also called family or parents board.
Physical disability	If one or more disorders to a certain extent lead to permanent limitations in physical functioning
Mental disability	A congenital or in early youth acquired limitation of mental functions and/or its further development possibilities; hereby the mental deficit is most striking while besides the social adaptation is made more difficult or impossible.
Multiple disability	We speak of a multiple disability if someone has two separate disabilities, each of them being serious, extensive and long-lasting.
IQ	Means Intelligence Quotient
Methodical approach	Approach according to a fixed, well-thought way of performing to reach a certain goal.
Care plan	A methodical document in care assistance and counselling
SMART – method	A way to formulate goals, giving direction to what you want to reach.
Pictograms	A simple picture/symbol replacing a text. There are various kinds of pictograms.
Social network	System of people who are close in touch with each other.

Appendices:

Qualification structure of education



	HEALTH CARE			SPORT	WELFARE			SERVICE PROVISION
LEVEL	Care	Nursing	Health care assistants	Sport and movement	Social Care work	Community work	Social services	Facility service provision
5 HBO*	TRANSFER TO HBO* LEVEL							
4 MBO* middle management training		Nurse	Pharmacist's assistant Doctor's assistant Dentist's assistant	Sport and exercise coordinator	Social care worker 4 Teaching assistant	Community worker		Facility services worker (level 4)
3 MBO* professional training	Care worker			Sport and exercise leader	Social care worker 3		Social services worker	
2 MBO* basic vocational training	Care helper			Sport and exercise supervisor	Social Care Helper			Facility services worker (level 2)
1 MBO* assistant training	Care assistant							
VMBO*								

Comment: The Qualification practical trainer is not part of one of the areas in particular. However, it is a qualification which occurs in the sectors Health Care, Service provision, Welfare and Sport.
* MBO = secondary vocational education HBO = higher vocational education VMBO = pre secondary vocational education

Curriculum: Social Care Worker

		Streaming out		
Core task	**Working process**	Social care worker	Handicapped care worker	Adults' social worker
1.Frame a counselling plan				
	1. Lists the client's care demands	X	X	X
	2. Writes the counselling plan		X	X
	3. Specifies the counselling plan into an activity plan.		X	X
2. Offer counselling and care, that activate and support				
	1. Stimulates the client's development	X	X	X
	2. Supports the client's personal treatment	X	X	X
	3. Performs technical actions related to the nursery		X	
	4. Supports the client's living and housekeeping	X	X	X
	5. Supports the client concerning job, education, and leisure	X	X	X
	6. Supports the control of the client's life		X	X
	7. Evaluates the offered support	X	X	X
3. Execute coordinating tasks				
	1. Coordinates the client's counselling and care		X	X
	2. Supports the client's social system		X	X
	3. Evaluates the coordination of counselling and care		X	X

Core task 1 Frame a counselling plan		Competences																								
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
	Working processes	Decision making & initiating activities	Management	Guidance	Showing attention & empathy	Cooperation and consultation	Performing ethically & with integrityy	Building relations and networks	Convincing & influencing	Presentation	Phrasing & reporting	Appliance of professional expertise	Appliance of materials and means	Analysis	Research	Creation and innovation	Learning	Planning and organising	Catering for the needs and expectations of the "client"	Providing quality	Complying with instructions and procedures	Dealing with change and adjustment	Dealing with stress and setbacks	Showing drive and ambition	Entrepreneurial and commercial performance	Acting in a businesslike manner
1.1	Listing the client's care demands				X							X			X				X							
1.2	Writing the counselling plan					X			X		X			X					X							
1.3	Specifying the counselling plan towards an activity plan.					X					X	X		X				X	X							

Core task 1 Frame a counselling plan		Competences																								
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
		Decision making & initiating activities	Management	Guidance	Showing attention & empathy	Cooperation and consultation	Performing ethically & with integrityy	Building relations and networks	Convincing & influencing	Presentation	Phrasing & reporting	Appliance of professional expertise	Appliance of materials and means	Analysis	Research	Creation and innovation	Learning	Planning and organising	Catering for the needs and expectations of the "client"	Providing quality	Complying with instructions and procedures	Dealing with change and adjustment	Dealing with stress and setbacks	Showing drive and ambition	Entrepreneurial and commercial performance	Acting in a businesslike manner
Working processes																										
1.1	Listing the client's care demands				X							X			X											
1.2	Writing the counselling plan					X			X		X			X					X							
1.3	Specifying the counselling plan towards an activity plan.					X					X	X		X				X	X							

Core task 2 Offer counselling and care, that activate and support		Competences																									
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
	Working processes	Decision making & initiating activities	Management	Guidance	Showing attention & empathy	Cooperation and consultation	integrityy	Building relations and networks	Convincing & influencing	Presentation	Phrasing & reporting	Appliance of professional expertise	Appliance of materials and means	Analysis	Research	Creation and innovation	Learning	Planning and organising	Catering for the needs and expectations of the "client"	Providing quality	Complying with instructions and procedures	Dealing with change and adjustment	Dealing with stress and setbacks	Showing drive and ambition	Entrepreneurial and commercial performance	Acting in a businesslike manner
2.1	Stimulating the client's development			X	X	X	X	X			X	X						X	X		X	X				
2.2	Supporting the client's personal treatment			X	X		X	X				X						X	X				X			
2.3	Performing technical acts related to the nursery	X							X		X	X	X								X					
2.4	Supporting the client's living and housekeeping			X	X	X							X								X					
2.5	Supporting the client in job, education and leisure			X	X	X		X					X					X								
2.6	Supporting the control of the client's life	X	X			X		X	X	X		X											X			
2.7	Evaluating the offered support					X					X	X		X	X		X									

Nuclear role 3 Execution of coordinating tasks		Competences																								
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
		Decision making & initiating activities	Management	Guidance	Showing attention & empathy	Cooperation and consultation	Performing ethically & with integrityy	Building relations and networks	Convincing & influencing	Presentation	Phrasing & reporting	Appliance of professional expertise	Appliance of materials and means	Analysis	Research	Creation and innovation	Learning	Planning and organising	Catering for the needs and expectations of the "client"	Providing quality	Complying with instructions and procedures	Dealing with change and adjustment	Dealing with stress and setbacks	Showing drive and ambition	Entrepreneurial and commercial performance	Acting in a businesslike manner
Working processes																										
3.1	Coordinates the client's counselling and care	X	X			X		X				X						X								
3.2	Supports the social system		X	X								X										X				
X	Evaluates the coordination of counselling and care										X	X		X	X		X									

X = level 3 social care worker

X = level 4 care worker for people with a disabillity

Notes

Notes

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