Personalised social support:
Thoughts, Method and Tools in an Approach of Proximity Social Services
Contents

Preface  page 04

Section 1  Principles and benchmarks  page 07
  ▶ Social work and development  page 08
  ▶ Personalised social support: generalities  page 15
  ▶ Personalised social support of persons with disabilities  page 23

Section 2  Practical guide  page 25
  ▶ Practical guide for social facilitators  page 26
  ▶ Practical guide for project managers  page 43

Section 3  Toolbox  page 49
  ▶ Stage 1: Initial contact  page 50
  ▶ Stage 2: Diagnosing the situation  page 51
  ▶ Stages 3 and 4: Defining, negotiating and planning the project  page 65
  ▶ Stage 5: Concluding a contract  page 67
  ▶ Stage 6: Implementing and monitoring the project  page 69
  ▶ Stage 7: Intermediary results analyses  page 70
  ▶ Stage 8: Finalizing the project  page 71

Bibliography and references  page 74
This is a methodological guide to **personalised social support**.

Offering a guide to understanding, thinking about and practicing this approach to social work, it is targeted at Handicap International field workers and public services or association advisers responsible for the reception, informing, guidance and support of persons with disabilities and other vulnerable groups.

Handicap International has been active in the field of support for a number of years, particularly as part of the policies and strategies implemented to develop health and the social inclusion services for persons with disabilities.

Albania... Training of social workers; Afghanistan... Community rehabilitation centre; Algeria... Socialisation spaces and implementation of the personalised project approach in reception facilities for children without families; Balkans... Psychosocial support project; Brazil... Experience of social projects; Cambodia... Social support for patients in the para/tetraplegic centre; Indonesia... Post-tsunami inclusion project; Madagascar... Social action bureau within local development projects; Morocco... Social participation project; Mali... Knowledge and exchange networks; Uzbekistan... Resource centres and social network; Romania... Aurora Project; Russia... Family support and networking of early intervention stakeholders; Rwanda... Inclusion project; Senegal... Community system for the identification and support of persons with disabilities in Casamance; Sierra Leone... Promoting the rights and social inclusion of persons with disabilities.

At the same time, considerable progress has been made in the development and organisation of the social work field in Western countries in recent years. We believe it is valuable and relevant to disseminate social work methods and tools in the field in order to meet the needs and expectations expressed in relation to understanding social work and its connection with Handicap International’s founding principles and concepts, ensuring the consistency of our operations and, above all, the methodological and technical support of field practices.

This guide also forms part of the study performed by Handicap International into the overall inclusion process for persons with disabilities and is related, among others, to the Disability Creation Process explicative model, the rights of persons with disabilities, and the Community Based Rehabilitation (CBR) participative and inclusive community development strategy - models and practices that are already widely used by our programmes. This guide also contributes to Handicap International’s capitalization work on CBR and follows the international seminars held in Peking and Bujumbura in 2009.

This guide to personalised social support can be used:

- As part of a specific social inclusion project, based on the implementation of a territorial social support process for persons with disabilities and other vulnerable persons, enabling them to access services and realise personalised projects.

- As a personal support aid for Handicap International development and emergency projects: health, rehabilitation, family and social life, education, professional life, urban development & disability, sport and leisure, etc.
- As an awareness-raising and training aid to enhance the skills and practices of professionals, stakeholders and local partners in reaching out to persons with disabilities and vulnerable persons, to ensure the notion of personalised social support is taken into consideration.

It is not designed to be used as an additional tool to be imposed upon the field, but rather to provide an explicatory tool and methodological advice on implementing and/or improving existing practices. Its content offers a framework for personalised social support and aims to provide practical and realistic, but also flexible and adaptable tools to meet the needs of field workers who provide support to persons with disabilities.

This guide is divided into three sections:

- Firstly, a "principles and benchmarks" section explores the theoretical aspects of social work, development and personalised social support.

- This section is followed by a “Practical guide” targeted at social workers, facilitators and advisers responsible for providing support and provides an in-depth guide to implementing personalised social support, based on various intervention techniques and practical tools. This “practical guide” also offers a section devoted to project managers or social mechanism coordinators, featuring benchmarks for the development and follow-up of a social support service.

- The third section features a “Toolbox” consisting mainly of tools sourced from Handicap International programmes.

Since it would have been difficult to include all of the available tools in a print publication, a CDROM has been added to this guide to offer a fairly comprehensive insight into existing tools which may then be adapted to various situations and field operations. Lastly, it is important to note that this guide forms part of a personalised social support learning process and you are therefore recommended to complete this learning process using training manuals, practical application experiences and other tools related to social work and development.

This guide has been developed based on information from a range of sources, including documentary research, the sharing of experiences and interviews with Handicap International professionals at head office and from the association’s programmes, exchanges with social action professionals, international and local development stakeholders. We were helped to address these issues thanks to the participation of the field teams, based on developed practices, questions raised and needs expressed, which were consolidated, among others, during an internal seminar on personalised social support that was organised in Lyon in December 2008.

We hope that this guide will offer a major lever to improve the social inclusion of persons with disabilities, by recognising the increasingly important role played by social facilitators, the central position and capacities of persons with disabilities, and finally the importance of this approach and the time needed to address to all change situations.
1. Social work and development
   - Social work: definitions and contexts
   - Focus on three areas of interaction

2. Personalised social support: generalities
   - Definition and objectives of personalised social support
   - Benefits of personalised social support
   - The systemic approach

3. Personalised social support of persons with disabilities
Based on humanist principles, the worlds of development and social work are closely interrelated. They both strive for the recognition of people experiencing difficulties, their access to rights, and endeavour to improve their quality of life, while increasing the social participation of each individual.

Social work has experienced a number of local, national and international challenges over the last twenty years. The impact of international agreements on the deregulation of the market place and of educational, health and social services establishments, has led international representatives of the profession, in particular the IFSW and IASSW, to define rules and agreements between countries in accordance with their specific historical and political contexts.

Meanwhile, governments, NGOs and other international organisations have been delegated the task of setting up programmes in the social work field.

To more effectively understand this interaction, we should examine some of the basic principles and objectives shared by development policies and social action policies:

**The goal:**
- Increasing people’s level self-reliance
- Mobilising individuals, families, organisations and communities in order to improve their quality of life
- Overcoming inequalities and injustice through the inclusion of marginalized, vulnerable or excluded groups or people in situations of risk
- Introducing social change (application of laws, influence over social policies).

**Different levels of impact:**
- Individual
- Family
- Community
- Society

**Key values:**
- The intrinsic value of each human being (equality for all)
- Human rights and social justice

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1. International Federation of Social Workers: [www.ifsw.org](http://www.ifsw.org)
2. International Association of Schools of Social Work: [www.iassw-aiets.org](http://www.iassw-aiets.org)
- The human development approach
- Placing value on potential and diversity
- The individual capacity to take an active role in personal development and decision-making
- Mutual respect and collective solidarity

**Resources employed:**
- Human behaviour theories/concepts
- Theories of human psychological development
- Theories of human communication
- Analyses of social systems
- Evaluation and intervention methods

► **SOCIAL WORK: DEFINITIONS AND INTERVENTION CONTEXTS**

**Definitions**

United Nations (1959):
“Social work is an activity aiming to help the reciprocal adaptation of individuals and their social environment, and reaches this objective through the use of techniques and methods enabling individuals, groups and communities to meet their needs and resolve problems arising from their adaptation to a changing world, and, through shared action, to improve economic and social conditions.”

In July 2001, the IASSW and the IFSW agreed on an international definition of Social work:
“The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work”.

3. Ref behaviourists (Pavlov and Watson) and cognitive theories (Lewin and Festinger)
4. Ref theories of Vygosky, Freud, Piaget, etc.
Background and contexts:

The practice of social work around the world changed significantly over the second half of the 20th century, due initially to the issues raised by refugees fleeing armed conflicts and famine. The growing mobility of populations, the increase in the number and location of conflicts around the world, and increasingly standardised cultures, led to the consideration of social work within an international framework. The creation of the International Federation of Social Workers in 1950 illustrates this trend.

The field of social work, more developed and structured in northern countries, therefore seeks to raise the awareness of civil society and public authorities to problems such as poverty, the situations facing vulnerable groups (older persons, persons with disabilities, orphans, refugees, etc.), the sick, poor access to education, illiteracy, the impact of war and natural disasters, etc.

At the end of the 1990s, Lionel H. Groulx, a social anthropologist from Quebec, identified three main configurations of social action observed in European countries, Quebec and the United States:

- **The socio-institutional model**: developed before the economic crisis, which specifies that only the State has the legitimacy to provide an institutional and universal response to social needs;
- **The neo-liberal model**: State aid should be limited to the most vulnerable. This leaves market forces to determine the response to social needs;
- **The socio-community model**: this also recommends the disengagement of the State in favour of communities in order to intermesh the community dynamic and to develop natural mutual-aid networks.

The changes in social contexts, behaviour, points of reference and values over the last twenty years have compelled social work practitioners, trainers and researchers to hold discussions at an international level in order to share suggestions for future approaches and to develop new intervention techniques.

At present, in developed countries, “the social work of the end of the last century has been impacted by three major changes. First of all, the density of social problems has changed over the last 20 or 30 years: poverty now centres on social exclusion and employment, the key vector for social inclusion. As such, social work has become more directly concerned with the workplace, a world absent from traditional social work in which economic considerations were simply not addressed. Secondly, state-provided social services have adopted a substantially modified intervention approach, meaning that social work (all categories combined) no longer belongs to one unique public welfare service - its reference point since the 1960s. As a consequence, it has had to interface with grass-roots organisations which, although now better understood and tolerated, objectively speaking, still remain “the competition” to public service organisations. Thirdly, there has been an upsurge in new practices – involving social work or not – within civil society and the public domain, focusing on three main issues: inclusion, local development and the social economy. These issues have combined in part with the regionalisation and decentralisation of several public policies. This marks another major shift away from traditional social work, which had, over the years, become increasingly specialised and sector-based (mental health, child protection, family interventions, interventions in aid of older people, etc.) as part of a centralised state-provider which exercised a quasi-monopoly over the production of public services.”

These issues also have an impact, to a point, on the practice of social work in most “southern” countries, even if social action policies and mechanisms are generally under-exploited or even, in certain cases, non-existent. Where they do exist, management and resources are centralised at a national level, the numbers of existing social workers are low and their room for manoeuvre is often limited. Nonetheless, the international community is increasingly involved in local development programmes in these countries, in line with the Millennium Development Goals, for example, and the facilitators of social work have an important role to play in them. The practice of social work, through its field of intervention (the individual, the community and its environment) and the methodology it employs (self-determination and participation) ties in well to different sorts of development programmes. The social work practiced in southern countries reflects the issues at stake in social work in the past, and yet is anchored in new ground, often far removed from the institutional constraints associated with developed countries, and thus providing scope for experimentation/innovation and renewal.

The International Association of Schools of Social Work aims to promote the development of social work training, along with the dissemination and formalization of social work practices, across the world. But these practices still remain rare in southern countries, little known by development bodies and professionals in the social field and barely recognised by States.

► FOCUS ON THREE AREAS OF INTERACTION

• Social Work and the Rights of Persons with Disabilities

The entry into force of the Convention on the Rights of Persons with Disabilities, or CRPD, in May 2008 marked the political and legal recognition of a better understanding of disability internationally resulting from debates that, over a number of years, changed people’s attitudes towards disabled persons. They are now primarily considered to be fully-fledged citizens and legal subjects capable of claiming their rights and making decisions about their own lives based on their free and informed consent as well as being active members of society; they are no longer perceived in relation to their impairments alone as objects for assistance.

The Convention is intended as a human rights instrument with an explicit, social development dimension. It reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms on an equal basis with others.

One of the historical foundations of social work is the defence of universal human rights and access to those rights. Social work has a key role to play in providing access to the community, developing empowerment and taking measures to promote particular populations. As mentioned later in this guide, “one of the main purposes of personalised social support is to enable vulnerable people/people in difficulty to access their full rights as a citizen.” It involves working towards a society in which everyone is able to play a full role by making individuals actors in their personal development.

The social facilitator works in reference to various existing legal frameworks: a social facilitator providing support, for example, to a child whose personalised project relates to inclusion in the mainstream school system, will base their actions on existing frameworks relating to education for all at a local, national and international level. The CDPH currently represents the only legally-

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binding instrument specifically devoted to people with disabilities; it does not create new rights, but brings together existing human rights provisions and humanitarian laws and aims to ensure that people with disabilities are able to fully exercise all of their human rights.

Referring to these frameworks, the social facilitator will identify local stakeholders responsible for implementing social policies and exploring how vulnerable groups are included in those policies. Within the framework of development projects, the role of the social facilitator will not be to criticise or highlight the failings of local stakeholders, but rather to support them in ensuring recognition for these groups and in fulfilling their service obligations towards these excluded people.

Personalised social support helps empower people to achieve their life goals, strengthening their self-determination:

- In individual terms, by enabling an individual to build up their capacities and decision-making powers by developing their self-confidence, self-esteem, sense of initiative and control over their own life.
- In group terms, self-determination results from taking part in political and group actions and requires the active participation of people to ensure the redistribution of resources favourable to the group.

“Self-determination is comprised of four key components: participation, competence, self-esteem and critical awareness (individual, group, social and political awareness). The interaction of these four components triggers a process of self-determination. This proactive process is centred on the strengths, rights and skills of individuals and the community, rather than impairments or needs.” (Anderson, 1996).

This process, made possible by a relationship of local support, requires the active participation of supported persons at every stage of the support process, from the diagnosis of the situation and the development and implementation of the personalised project to its completion. For this, the social facilitator must know how to address the most vulnerable people and develop appropriate methods throughout the support process to strengthen its impact on these people who have been neglected by social services.
Based on the model of universal human development, and therefore applicable to all human beings, the Disability Creation Process (DCP) is a social disability model.

It encourages the perception of disability as:
- a changing state rather than a fixed one
- a situation which varies according to context and environment
- a state which can be modified by reducing impairments and/or developing abilities and/or adapting to the environment

According to the DCP, a “situation of disability” is the result of interactions between personal factors\textsuperscript{11} and environmental factors\textsuperscript{12} with regards to a life habit / activity of daily living (ADL). The “situation of disability” is therefore considered a limitation on performing that life habit / ADL. Conversely, the DCP refers to full social participation when a person is able to perform all of their life habits/ADL. Each of these factors is analysed in accordance with a scale measuring physical and mental integrity through to impairments, capacity though to incapacity, facilitators through to obstacles and social participation through to the situation of disability.

In the DCP context, the list of life habits can be used as a tool to measure social participation. A life habit is a daily activity (or a “social role”) valued by the person or his or her socio-cultural context, and assures the survival and fulfilment of an individual throughout his or her life in the community.

Likewise, social work tools, both in terms of their theoretical definitions and practical applications, enable us to analyse the relationship between an individual and their environment and their degree of participation and involvement within this environment. They also help determine what falls within the scope of individual responsibility and that of social responsibility.

\textsuperscript{10} “Disability Creation Process, individual, social and systemic approach to disability”, Patrick Fougeyrollas, October 2006
\textsuperscript{11} Ref list of personal factors in the tool box, introducing practical tools for the social diagnosis
\textsuperscript{12} Ref list of environmental factors in the tool box, introducing practical tools for the social diagnosis
In this context, and particularly within a personalised social support framework, the list of life habits can be used as a reference point for the development of a personalised project, consisting of the evaluation of a person’s request, the definition of their needs, and the goals to attain.

For example, a personalised project can be developed around a wish to improve the performance of current life habits or around future life habits not yet performed.

**Social work and Community Based Rehabilitation**

**CBR and Disability**

*Definition provided by the WHO, the ILO and UNESCO in 1994*

“CBR (Community-Based Rehabilitation) is a strategy forming part of a framework of community development for the rehabilitation, equalisation of opportunity, reduction of poverty and social inclusion of all persons with disabilities. Its implementation requires the combined efforts of people in disabling situations, their families and communities, social, health and educational services and training”.

The Community Based Rehabilitation (CBR) objectives are:

1. Ensuring that persons with disabilities are able to optimise their physical and mental abilities, access services and opportunities offered to the general population and become active contributors to the community and society as a whole.
2. Motivating communities to promote and protect the human rights of persons with disabilities through reforms designed to, for example, remove obstacles to social participation.

As an element of social policy, the CBR focuses on the right of persons with disabilities to live within their community, to enjoy a state of well-being and good health, and to participate fully in educational, social, cultural, religious, economic and political activities. The CBR requires governments to delegate the necessary responsibilities and resources to communities to enable them to perform basic rehabilitation actions.

Social work can take different forms as part of a CBR approach. Firstly, within a context in which resources exist but are not accessible, it is possible to set up services where people with specific needs can go to obtain the information desired. This activity, which we can call “information/guidance”, requires excellent listening skills on the part of the social facilitator and the continuous updating of a list of available and adapted services within a given territory. Next, if a group is isolated or experiencing difficulties identifying their needs, a guidance/information service may not be sufficient and should be supplemented by a personalised social support process. Lastly, if services do not exist or are underdeveloped, the social worker will sometimes be provided with basic skills in physical rehabilitation, professional inclusion, education and other areas, in order to supply a minimum response when implementing personalised projects.

The social facilitator, also known sometimes as the CBR officer in this community practice context, plays an important role in “creating ties” and “mediating” between the groups, the different stakeholders involved in the relational system (family, friends, employers, institutional representatives, associative partners, other professionals, etc.) and the services placed at their disposal. These social work practices link two different life spaces: the personal sphere and the collective sphere. They aim to connect up the individual characteristics and the collective and/or community characteristics of a particular territory in which persons with disabilities exist.
The meaning of the word “support” has changed over the years. If we refer to its etymological roots, the word “support” comes from the Latin verb “supportare” which means “convey, carry, bring up”. Other Latin origins include “sub”, from below, and “portare”, to carry. The first use of the noun support is recorded from 1385 with the meaning “take responsibility for, to relieve, to help one another”. In 1963, it appears for the first time with the meaning of “encourage, provide help”.

Although it suggests a relational dynamic between two or more people, and is frequently used within a social work context, the current meaning of this word is subject to debate. These debates focus on the dynamic generated by a “support” relationship, suggesting an inequality between the stakeholders concerned: the strong “supporter” playing the major role and the passive “person supported” receiving the support. Many social facilitators in the past have therefore rejected the word “support” because of its negative connotations, associating it with condescending charitable actions.

However, within the framework of this guide, the use of the expression “personalised social support” refers, on the contrary, to positive notions of social participation and empowerment.

Sometimes used as a synonym for counselling, “support” is now a fashionable word, a catch-all, convenient word that can take several forms: learning support, pupil support, personalised social support, peer counselling, emotional support, psychological counselling, moral support, bereavement counselling, etc.

Social support is considered to differ from past forms of follow-up in that it is not uniquely centred on the person but includes working to forge links with services, the identification of responses, their relevance to each user’s situation and the groundwork needed to develop the capacity to receive them.

Personalised social support is the result of the development of specific social trends and the use of new social work intervention methodologies, introduced at the end of the 1980s. Originating from the United States, and resulting from studies of psychotherapeutic and systemic practices, it encourages a global approach to the individual whilst proposing a customized model.

Contrary to traditional practices in social work, based on a structure consisting in a professional with a mandate and a care-managed user, personalised social support is based on the ethics of a mutual commitment between the parties involved (the notion of a common trajectory).

**Why “personalised”?**

The notion of an individual (etymologically speaking, “that which cannot be divided”), expresses the idea of unity, whilst that of a person (derived from the Latin ‘persona’, “mask”, and by extension, “character” or “role”) refers to singularity, to a figure. As a consequence, personalisation does not convey the same idea as individualisation, i.e. a reduction to an undividable unit.
DEFINITION AND OBJECTIVES OF PERSONALISED SOCIAL SUPPORT

Social support:
The social support concept consists of three components:

- **A relational component** (to be with), that is the quality of the relationship (understanding and mutual respect) which will, to a large extent, determine its success.

- **A component consisting of change and movement** towards a new (and better) situation. The supporter is:
  . In front, to spur on, but not too much, because often people “run” behind the social facilitators.
  . Side by side, to share, build together and negotiate.
  . Behind, to allow the person to make their own way, but also to support and “pick up” or “push” in the event of failure or fatigue.

- **Time component**: Social support has a beginning and an end that must be determined in agreement with the person involved. It must comply with the intervention framework (length of the programme) but also the pace of the person in question. The goals to achieve and their planning will help in organising how time is used. **Support must never last too long**, because it could become a sign of interdependence between the social adviser and the person supported.

“Personalised social support can be defined as a voluntary and interactive approach involving participative methods with the person asking for or accepting assistance, with the objective of improving their situation and relationship with their environment or even transforming them. [...] Social support provided to a person is based on respect and the intrinsic value of each individual, as a party to and subject of rights and obligations”.13
It consists in an intervention method that supposes the triangulation of three factors:
- a beneficiary (the user)
- an action mechanism in a given environment (a project, a service)
- a facilitator (the social worker or social adviser)

Personalised social support is based on a global analysis of a person’s life and aims to foster their empowerment by helping them to better formulate and organise the preparation and realisation of a (personalised) project.

In the words of facilitators in the field...

- **Partner association of Inter Aide on a support project in Bombay (India)**
  “Social support aims to build up a person’s self-confidence so they become self-reliant. The level of self-reliance is measured by the capacity of the person to resolve their own problems, see projects through and help others.”

- **The Algerian Physical Disability Federation (FAHM), Algeria**
  The supporter:
  - **Is a facilitator**, a pilot: they will support the person in finding, for him or herself, the solutions most relevant and suited to their situation.
  - **“Walks alongside”**: they accompany people but do not act or decide for them. Take, for example the young girl who did not want the sewing machine brought by the social worker because, for her, developing a sewing business would entail staying shut away in her small village, when she actually wanted to do something that would enable her to end this exclusion.
  - **Listens to people, welcoming emotion** and feelings. For example, when a person has experienced a series of failures, it will be difficult for them to enter into the project dynamic if they have been unable to express their fear of the future, lack of self-confidence, and occasional anger at their lack of acceptance. By expressing their emotions, a person is able to better imagine future possibilities.
  - **Ensures that basic needs are met**. We cannot anticipate the future if our basic needs (food, shelter, not risking our lives when we move around) are not met.
  - **Refers to other professionals**: the inclusion worker does not work alone, they are part of a team and work in tandem with others, even if they are still the key adviser of the person they are supporting.
  - **Takes into account the person’s entourage**. The family may be a spur or an obstacle to change. As such, it is necessary to associate the family with the project, while enabling them to understand its purpose. The person may be called upon to help their family to change: “how do you think that your family could be convinced to accept that you take this training course? Which member of your family could help you convince your father (or mother), who appears to be against it?” It is always preferable that the person themselves remains the driving force of change in their entourage, rather than the inclusion worker. On the one hand, because this approach strengthens the person’s feeling of self-confidence and, on the other hand, because it is better accepted by the family, which does not always appreciate “outside intervention” in its organisation.
  - **“Pieces together the puzzle”**: very often, the inclusion worker will support the person in restoring meaning to their life by “centring” it around a project, rather than through separate and unrealistic projects.
  - **Gives “colour”**: the inclusion worker, based on their vision of the “future” person, does not reduce them to their disability or problems. They see in that person what they could become (possibilities and potential) and does not focus on their problems.
Personalised support allows a person to:

- Explore their fields of interest;
- Define their needs;
- Develop or maintain capacities, attitudes or behaviour that could be useful to them;
- Find ways to remove obstacles to their personal, social or professional progress.

As each individual is unique, they require a particular methodology to be adapted to them.

**In the words of facilitators in the field...**

- Emmanuelle Six, social worker, Desk Officer for Inter Aide

  “Social support consists of guiding people suffering from a lack of everyday resources (material, psychological, inter-personal, cultural, etc.) in the realisation of a personal project adapted to their capacities and environment, taking into account norms and social life (recognised by public opinion and legal authorities).”

**BENEFITS OF PERSONALISED SOCIAL SUPPORT**

The personalised social support service is a useful tool for social inclusion and the empowerment and self-determination of individuals, and presents a great many benefits due to the links it creates between the forces and stakeholders in a given place and time. It can have an undeniable impact/effect in bringing about change.

**Goals**

- Contributing to improved social inclusion for the user/participant/beneficiary, taking a global and personalised approach to their situation;
- Developing the involvement of people in their own process of change through improved management of their interaction with their environment by fostering their empowerment and self-determination;
- Helping create a more positive self-image by increasing their self-confidence and awareness of their personal capacities.

**Role in environment**

- Analysing the cross-cutting and complementary aspects of goods and services that facilitate the social inclusion of certain people;
- Helping ensure the consistency of regional projects and mechanisms;
- Facilitating interaction between existing systems (medical, social, professional, economic, leisure, etc.);
- Encouraging the creation and reinforcement of working groups and networks, reinforcing a multidisciplinary approach.

**Methods and tools**

- Listening, empathising, encouraging;
- Constructive approach “what we can do” rather than “what we cannot do/can no longer do”, based on existing positive points;
- Adaptation to field specificities and different contexts;
- Models of intervention practices based on cultural, religious and historical characteristics;
Observatory function

- Identifying, appreciating and summarising the types of needs and demands in a given region / territory (familiarity with and analysis of regional stakeholders, the public targeted and their demands, etc.)

Related effects

- Directly questioning the role of the family, inter-personal and social environments in the person’s development;
- Modifying the outlook of professionals, participants and the community on differences.

THE SYSTEMIC APPROACH

A person evolves in different dimensions - physical, psychological, social and spiritual. These dimensions match up with the different aspects of their existence (body, thoughts, values and beliefs), relationships with others and the world (family, close circle) and existential motivation (the place and role they attribute to themselves in this world).

Building up a relationship and communicating with others, taking part in social support, implies taking into consideration all aspects of the other person in order to get to know them and to understand them better.

The context in which a person exists takes into account the values of the society they live in and those of the group they belong to, so it is critical to take contextual considerations into account and distinguish collective social, national and international norms (health, education, human rights) from the subjective representations of each individual. Taking into account local values and deciphering value systems specific to a territory are important and guarantee the results of a coherent and effective support process.

In social work, particularly within a personalised social support process framework, certain facilitators base their actions on the systemic approach. This method was first introduced in the United States in the 1940s and is based on studies in the fields of psychosociology and communication. It considers that each human being coexists within several different systems at once and that all these systems influence each other. In any given context, an individual is therefore constantly interacting with the environment and other members of the group they belong to. The behaviour of each member of the group is linked to the behaviour of all the others, and depends directly on it.

Furthermore, the systemic approach considers that whatever causes a problem in a given situation is not the symptom of a malaise or malfunctioning but of the context of which it forms part.

As part of a social support process, the systemic approach enables us to improve the organisation of a personalised project, take into account the different elements and include all members of each of the systems in drawing up an action plan. In addition, it leads to the identification and understanding of the role and function of each person at an individual level and, by extension, at a group and community level.
The systemic approach also brings to light a certain number of elements common to each of the systems involved, using them as a basis for diagnosing the global situation of an individual, or, for example, a family, community or business.

**The aim:** why does such a group or community exist? What makes up its existence? (A sense of belonging, a process of identification, etc.)

**The alliances:** who makes up the alliances, to what end (power, coalition, etc)? How are they modified?

**The space:** what is the physical and relational space? Who is close to whom? Who is kept at a distance? Who is isolated?

**Gravitational forces:** who does the group depend on? Whom do they turn to in the event of need? What characteristics do these people have?

**The limits and boundaries:** each person has his or her own boundaries, which provide them with autonomy whilst sharing group space. There are also boundaries between generations.

**The roles:** who contributes to the groups’ needs? Who manages the finances? Who sets the limits? Who authorises them? Who forbids them? Who suffers? Who is accorded positive recognition? Who is the leader/looked up to? Who is the scapegoat?

**The positions:** each person holds a position allowing them to be recognised by others, maintain their self-esteem and move on. What is the position held by children? What is the position held by adults? What are the boundaries and modes of communication between them?

**The rules:** what are the common rules? The implicit rules? Who governs the actions and reactions linked to the established rules?

**The values:** what are the mental and emotional representations? The cultural and/or religious values? What is good? What is evil?

**The beliefs:** what are the family and community beliefs? What is the common outlook on a particular society-based issue? On a particular myth or reality?
Several benchmarks

The systemic approach entails analysing a situation as a whole, and focusing on the person’s potential rather than what they cannot do. The person should not be reduced to their problems or disability. In this regard, the principles are as follows:

- **All systems (person, family, group, community, etc.) contain the solutions to the problems they encounter.**

  During crises or periods of necessary change, if the system does not identify a solution, the signs of suffering of one or several of its members will attract the attention of the “supporter”. As a result, in a problematic situation, solutions should always preferably be looked for in the context. Solutions imposed from outside, unsuited to the context, are rarely sustainable and meaningful for families/communities, often leading to the failure or destabilisation of the system in place.

- **All systems (person, family, group, etc.), even in a situation of heightened vulnerability, possess capacities and resources capable of being mobilized to their advantage.**

  Piaget, an educational expert, said that every time someone gives a solution to a child or to another individual, or if they do things for them, they deprive them of the experience of searching for and finding out how by themselves. It is this experience that enables them to build their self-confidence and self-esteem. It is still important, however, to point out that, in a social work situation (emergency and development), some people are in such a state of deprivation that they should be given the means to meet their basic needs. This is a necessary and essential step to complete before mobilizing the system’s capacities.

- **All systems develop in their own way. The same situations do not necessarily produce the same effects and there are several means of bringing about change.**

  This means two things:
  a) We do not need to “condemn people from the start”. For example, a beaten child will not necessarily become an abusive parent. However, if we are convinced that they will be one, we risk creating a situation (fear, control) that will favour this attitude.
  b) There is no one way to bring about change. There are always several possible solutions. As such, in terms of support, there is no ideal solution to find and apply.

- **A human system is a living system, a vehicle of life cycles.**

  Some periods are marked by construction (of the married or parental couple, for example), and others are characterised by development. To be transformed, all systems pass through periods of crisis (times of change) which correspond to the passage from one state to another. For example, a young couple is going to experience a period of instability with the arrival of their first child and the discovery of what it is like to be parents. It will be the same with children, when they leave the family home, experience death or illness, or the development of an impairment by one of the members of their family.

- **Systems are influenced by surrounding systems that they influence in their turn (ecosystem)**

  As such, a family interacts with educational and professional systems and circles of friends, but also with political systems, cultural and religious value systems, etc. The more open the system, the greater the level of interaction. In a totalitarian system, the level of interaction is low and influences are unilateral. In a more democratic system, families with a low level of interaction (little solidarity, little openness to the outside) often have greater difficulty in transforming themselves and the crises they experience can be long and destructive.

Most of the time, the systems find the capacity to transform themselves. When the external “influences” are too great or too violent (natural disasters, war, etc.) external aid is necessary, but it is also useful when the system is unable to move from one state to another. For example, some families do not accept that their child with a disability should leave the home because all of the
family’s members have built their lives around the disability. Each has found a function and a role in this situation, and no one wants to lose them since they cannot imagine another way of life.

- **The ecosystem approach**
  
  **The process: “It takes a whole village to raise a child”**

The approach adopted is based on the interaction between the individual and all of their environments, which are interdependent and influence their behaviour, development and quality of life. As such, certain environments have a direct impact on the child (family, school reception spaces); others have more of an indirect impact, such as the laws and cultural habits of the country or region in which they live.

There are five systemic levels:

- **The autosystem**: characteristics of the individual: age, gender, capacities, disability.
- **The microsystem**: surrounding environments: family, school, work environment, reception centre, etc.
- **The exosystem**: environments in which a person is not directly involved but which impact on their direct environment: work environment of parents, community infrastructures, family assistance and support mechanisms.
- **The macrosystem**: all of the values, beliefs, ideologies and political orientations present in a society.
- **The mesosystem**: consisting of interactions between different systems. The interactions between systems or the elements of systems are relational spaces that provide us with information enabling us to evaluate the resources of a system and to anticipate the actions to take. Strengthening these links through more effective coordination can, for example, provide favourable conditions for the inclusion of individuals.

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14. The environment is defined as a set of structures, social and human organisations, regulations and mechanisms or rules that fit into each other and influence one another reciprocally.
In the words of social action professionals...

- **Jean-René Loubat, French psycho-sociologist:**
  “Personalised support, a method borrowed from English-speaking countries, is perfectly transferable to persons with disabilities because it involves medico-social action, and even health and sanitary issues. It is as much about providing advice, stimulating, encouraging and aiming for a moral rehabilitation of disability as supplying practical assistance for the management of a global situation.”

- **Erik Jaubertie**, director of a medico-professional institute:
  “Social support aims to ensure the inclusion and integration of persons with disabilities. The organisation of their life plans depends on the image they have of society (how it works, its rules and values) and the limits they impose on themselves based on their education and personal histories.”

It is critical to note at this point that the **personalised social support of persons with disabilities does not differ in its concepts and principles to the personalised social support of any other vulnerable group of people**. It stands out, however, in terms of the need to take into consideration, the impact of the impairment on the person’s personal experiences, the need to understand the social image of the person (most often discriminatory) and, above all, the possible adaptations of social support methods and tools to different types of impairments and capacities.

We have chosen not to go into the details of impairments and the particularities of their care-management. Discussions between the social facilitator and members of the medical and/or para-medical profession is strongly encouraged and fosters a better understanding of the impact of an impairment on a person’s daily life and will facilitate the development of the personalised project.

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15. "L’accompagnement social des usagers de centre d’aide par le travail”, 2001
The social support of persons with disabilities can have the particularity of **mobilising a great many different facilitators** (medical, paramedical, social, family-based, etc.) It is therefore even more important that the social facilitator plays their role as coordinator and mediator in order to ensure the full and joint participation of each party in the improvement of the supported person’s quality of life, and that they clarify their own tasks and skills in order not to “overlap” with those of others, and therefore lose their relevance.

Whatever the impairment, it is important to note that the person living with a disability has had to build or re-build his or her self image whilst carrying out a “mourning process for his or her healthy state”. This “mourning” takes time, and above all can render the person considerably more fragile, particularly in their relationships with “others” in which they no longer recognise themselves. The social facilitator should therefore be extremely attentive to people’s personal histories, and weigh up the time and space required for such “mourning”, if it has not yet taken place.

**Practical advice:**
- The social facilitator should be in contact and hold regular discussions with the medical and paramedical professionals responsible for the functional rehabilitation and rehabilitation of the supported person. The construction of a personalised project for a person with disabilities should take into account medical and paramedical opinions regarding the realism and feasibility of the project. The project can fix goals and become a source of motivation for improving a person’s capacities during any functional rehabilitation. If there are no such rehabilitation professionals in the intervention region, the social adviser should take even more care to discuss a realistic personalised project, bringing out and building on the existing capacities of the person with disabilities.

Without going into the details of the different types of impairments, it is nonetheless important to point out the particularities of intellectual impairment. Social accompaniment of a person with an intellectual impairment requires, in most cases, the presence of a third party, being the person responsible (legal or family) for the supported person. The social facilitator should take care to maintain a privileged relationship with the person with the disability, and remain the sole person in charge of the personalised project, even if they look for support from the person responsible for the project’s success. It is also important that the social facilitator differentiates between the wishes of the supported person and the wishes of the responsible person, which is not always an easy task. The different experiences acquired by Handicap International in the social support of persons with intellectual impairments have shown that the process often shakes up existing family relationships, and negotiated personalised projects often tend to resemble personalised projects negotiated for the families rather than for the person with the disability. This should not be rejected outright, but the social facilitator should bear in mind that their “direct beneficiary” remains, and must remain, the person with the disability.
1. Practical guide for social facilitators
   - Implementation of personalised social support
   - Outline and detailed stages of personalised social support
   - Role and posture of the social facilitator in the social support process

2. Practical guide for project managers
   - Prerequisites for the development of a social support service
   - Implementing the social support process: practical advice for the field
   - Profile of social facilitators / advisers
First and foremost, it is important to specify the choice of terminology employed in this document. Qualifications, experience, status and professional contexts are variable, so a “social adviser” can be called a “social worker”, “inclusion officer”, “CBR officer”, “counsellor”, “community worker”, “social intermediary”, “social officer”, “on-hand officer”, or “social facilitator”. We have chosen the term “social adviser” and “social facilitator” for this document, both of which cover social work professionals (inclusion officers, facilitators, youth workers) and non-professionals (other professionals trained in social support, volunteers, field officers, community workers) who carry out their missions by following the steps outlined in this guideline. We nonetheless recommend these missions to be carried out by a social work professional whenever possible.

Likewise, when referring to the person concerned by the support, we do not use the term “beneficiary” or “client” (a term more associated with the delivery of a contracted service), but rather “supported person”, or “participant” in the context of a community project, or “user” in the context of a service provided.
This involves working on the **two levels** in question:

- **The person**
  
  **Support relationship (the dual supporter/supported person relationship)**
  
  This relationship aims to recognise the capacity of a person to be, to exercise a decision-making power and to establish relationships of trust with others. This relationship is a type of support, similar to material and human support, which can be supplied to solve a mobility or accessibility problem or the cost of a specific need.

- **The person’s environment**
  
  **The environment in which this relation develops (the context)**
  
  The social adviser must encourage relationships with the environment by forging or restoring social ties and respect for differences and by stimulating local solidarity. They assume the role of awareness-raiser and mediator, and participate in making others aware of the issues at stake and changing their behaviour accordingly. They foster the mobilisation of partners through the development of partnerships and help achieve the social cohesion of services for users.

**OUTLINE AND DETAILED STAGES OF PERSONALISED SOCIAL SUPPORT**

- **The main steps involved in the support process:**

  **Defining the supported person’s needs**

  - Collecting information from the **person concerned**
  - Processing this information with the aim of drawing up an overview of the needs and expectations
  
  - Interview with the family, third parties, possibly a legal representative and professionals associated with the diagnosis
  - Processing this information with the aim of drawing up a general overview of the situation

  **Proposing different possible responses**

  Drawing up an action plan for determining the responses to needs for each of the planned activities

  **Contract**

  **Keeping informed and negotiating**

  - Providing feedback to the supported person
  - Providing feedback to the family, third parties or the legal representative

  **Coordinating and monitoring the project**

  - Alongside the person concerned
  - Alongside the family or legal representative
  - Alongside the partners
The personalised social support process is divided in eight stages, from the initial contact, to the exit from the support process. These stages are illustrated below and will be detailed in the following section.

**Stage 1:** Initial contact and/or considering demands

**Stage 2:** Diagnosing the situation

**Stage 3:** Definition and negotiation of the personalised project

**Stage 4:** Defining the action plan

**Stage 5:** Concluding a contract

**Stage 6:** Implementing and monitoring the project

**Stage 7:** Intermediary results analyses

**Stage 8:** Finalizing the support

Realising the project and achieving self-reliance, empowerment
STAGE 1: INITIAL CONTACT AND/OR CONSIDERING THE DEMANDS

Why?
To make contact, build up trust and carry out a global analysis of the appropriateness of personalised social support services on offer with regard to the demand.

How?
• Providing a professional’s listening ear and attention
• Holding an open discussion
• Understanding the demand and appropriateness with the personalised social support services available
• Reviewing the framework and personalised social services proposed

Practical advice:
• The material conditions of the interview are important. Whenever possible, this first contact should take place in a neutral environment for the person, i.e. not in their home. The social support process requires a space apart, equipped with a desk and chairs, in order to ensure the confidentiality of discussions. If this is not possible, then a public place should be used, bearing no particular significance for either of the participants (e.g. a café, a public park, the village square, etc.) All this encourages open discussion and getting to know one other.
• During the discussion, it is important to take time for introductions and reminding the person seeking support of the framework and objectives of the discussion (getting to know one other, listening to the demand or project outline, collecting information in order to understand the situation properly, etc.). The principle of confidentiality should also be highlighted (anything passed on to a third party should directly concern the realisation of the personalised project and requires the authorisation of the supported person before it is communicated).
• If the “services” offered correspond to the demand and/or expressed needs, the social adviser then proposes a formal meeting (usually at the person’s home) to carry out the next step: (a) diagnostic interview(s).
• It is possible, during the first interview, that a person expresses only a need for information and guidance, for a personalised project that is already well-established. In fact, in this case, it is necessary to check if the person really requires a personalised social support “service” or if occasional information/guidance would be better suited to their situation. If such is the case, following this initial contact, the social support process does not need to be continued.

STAGE 2: DIAGNOSING THE SITUATION

Why?
To evaluate a person’s life situation.
Based on the first interview (ideally in the person’s home), the facilitator collects information from the person and their entourage, in order to perform a general analysis of the situation. In reference to the information collected, the facilitator may consult other professionals (doctors, employers, other social workers, etc.) to complement the data collection process. The comparison and analysis of this information will enable them to measure, with reference to identified needs, the personal and environmental factors to be considered when drawing up the personalised project.
How?

- Collecting information on the person’s personal and environmental sphere, with regards to their activities of daily living.
- Identifying disabling situations.
- Evaluating the request and the needs identified by the person and those close to them as priorities.
- Updating and completing the data collection, with regards to the needs identified.
- If required and possible, multidisciplinary evaluations (medical, rehabilitation, psychological, educational, social, professional, etc.) in order to complete the data collected.
- Analysing the data with the definition of facilitators, obstacles, and the person’s capacities and incapacities.

Practical advice

- The purpose of interviews, their length and the points to be addressed should be specified before the interviews begin.
- Drawing up an outline for the interview can help the social adviser to go through all the points to address, but the aim of this first meeting is to encourage in situ verbal discussion.
- The evaluation process is based on data collection, analysing the data and defining subsequent recommendations. It is an important stage in the support process, but also a delicate one because it requires the facilitator to listen carefully and produce subtle analyses.
- The social diagnosis requires “global” information collection, relating to the different spheres of the person’s life. However, it should be noted that it is not necessary to collect all of the information in the same detail. This could lead to a diagnosis lasting over several weeks, with a lack of understanding on the part of the person involved in the process. The length of the process can sometimes lead to needs being met even before an overall picture of the situation has been achieved, and therefore without taking into account and prioritising the person’s real needs. It is therefore preferable to get an overall but succinct picture of the person’s situation, then to complete the data collection and the analysis with regards to the difficulties and needs noted by the person, their entourage and social facilitator.
- The evaluation can be performed in several stages and over different time scales. It is not the social worker’s role to provide technical expertise in relation to specific areas (muscular assessments, learning capacities, etc.) but rather to promote a comprehensive social diagnosis. To achieve this, according to the needs identified, a multidisciplinary approach should be taken during the data collection process.
- One of the social adviser’s difficulties during this exercise is being aware of their own subjectivity as well as the subjectivity of the other person. What counts is the person’s subjective manner of dealing with the situation requiring improvement, and not the social adviser’s idea of the reality of the situation, or what would be best for the participant.

16. Ref annexe “tool box”
The social diagnosis

“Drawing up a social diagnosis is a critical stage in social work. Whereas a medical diagnosis precedes treatment, social diagnosis simultaneously gathers together facts, analyses them and applies them with care in order to understand the person, their situation and environment with regards to their relationship with the service proposed. They then proceed to the implementation of a social work project [...].

The word “diagnosis” signifies “knowledge” in Greek, and covers the identification of a disease according to its symptoms. In the case of social diagnosis, the word has a wider meaning. It contains two aspects: a careful search for the facts determining the nature of things and the decision or opinion resulting from such an examination or investigation. The term social indicates its nature, i.e. that it concerns a person in his or her own situation. Several authors prefer the term evaluation, which only implies a preliminary evaluation and not an understanding of the nature of the situation. Yet this latter forms the main element of a social diagnosis.

In social work, making a diagnosis involves using the concept of interaction between people and their environment. The social diagnosis is a process as much as a stage. Basing him or herself on facts, the social worker tries to understand the person’s system and form an opinion on the nature of the sub-systems making up their environment. This is examined as part of the systemic approach framework. [...] An important aspect of diagnosis in social work [...] consists of evaluating the person’s possible contribution to the group’s efforts, as much as the benefit gained by the rest of the group from this contribution.

Social diagnosis is not just the fruit of rigorous efforts, but also of communication with other people, groups, institutions and the social environment. If they do not participate in the diagnosis, it is no longer a social diagnosis but a study of a phenomenon.”

Conducting interviews

An interview can be an evaluation tool. It focuses on persons or situations and consists of two aspects: collecting information and regulation.

<table>
<thead>
<tr>
<th>Collecting information</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>This aspect corresponds to a mass of informative elements which will assist with deciphering and analysing the situation.</td>
<td>This aspect aims to ensure that the interview goes well by focusing on manifested attitudes (non-verbal communication, behaviour, emotions) and allowing the course of the interview to be adapted and reformulated in accordance with what the other has to say.</td>
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The interview is based on listening and observing

Listening, an interpersonal communication technique, is founded on the notions of respect, empathy and trust. It requires paying particular attention to what is being said and our understanding of it. Careful listening can provide understanding of the facilitators and obstacles encountered in the person’s daily experiences, their desires, suffering and future plans. During an interview, listening is required to ensure communication and to build up a full understanding of the situation and guarantees appropriate responses.
Generally speaking, there are three interview techniques:

- **The unstructured interview** is used to add depth to knowledge of a global situation, leaving the person concerned to speak at will. Formulated questions are rare and kept open, rendering the dialogue more of a conversation.

- **The semi-structured interview** is structured according to detailed themes that the interviewer wishes to explore in more depth. It uses an interview outline listing and ranking the themes or specific issues to be addressed. The focus is more on the person, and understanding them better. Questions are normally open, avoiding yes and no answers.

- **The structured interview** is used to address a specific theme by adopting an enquiry approach. It often involves a series of closed questions posed in an interrogatory fashion, directing the focus more on the theme in question than the person him or herself.

The unstructured interview seems to be the format best adapted to personalised support, but requires a real mastery of interview techniques. If such mastery does not exist, the semi-structured interview is highly recommended. It encourages free discussion, a critical element in an interview of quality, whilst helping the adviser to conduct the interview through the use of a flexible framework and an interview outline. Nonetheless, it is important to note that the type of interview must above all be chosen according to the cultural context and framework of reference in which it takes place. The adviser has to decide how to initiate a relationship with the supported person, in accordance with the latter’s life habits and “communication preferences”. This demonstrates that the adviser accepts to function in a way that suits the other, even if modifications can be introduced at a later stage.

**Some advice for establishing good communication:**
- Greet the person in a welcoming manner and show them your availability
- Speak to them about personal, positive issues
- Start from shared experiences
- Emphasise the strengths and positive points in the person’s history
- Pose simple and clear questions, reformulating them if the person does not seem to understand
- Pay attention to non-verbal communication: looks, gestures, emotions (anger, fear, anxiety)
- Create a good atmosphere
- Show determination, commitment, belief and a will to improve the situation

**Some technical advice:**
- Disassociate listening from discussion and reformulate what has been said
- Stay attentive to what is observed (seen and heard) without looking to interpret and understand it
- Summarise what is said as the interview progresses
- Avoid slanted questions that beg the answers
- Opt for open questions (why....? how...?)
- Re-launch the discussion when necessary. Rephrase what has just been said, allowing the person to explore his or her thoughts and feelings further (If I’ve understood you correctly...? And then you...)
- If the person does not agree with your re-formulation, they will explain why, thus re-launching the discussion.
The practice of evaluating the situation

During the support process, the development of a personalised project is based on an evaluation. This is an important stage. It is critical to disassociate the individual’s demand, wishes and expectations from the identified needs and the resources required to fulfil them.

Evaluating the situation is a delicate process. It aims to expose the subjectivity of the situation experienced by the person. The adviser needs to try and evaluate the obstacles encountered by the person, disassociating them from his or her own ideas of reality and avoiding judgements.

The table below shows the different linkages in the evaluation process and some tips for its practical rollout, with the participation of the person him or herself who must remain in control and involved throughout.

<table>
<thead>
<tr>
<th>Gathering information</th>
<th>Understanding the situation</th>
<th>Making proposals</th>
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<tbody>
<tr>
<td>(data collection)</td>
<td>(analysing the data)</td>
<td>(making recommendations)</td>
</tr>
<tr>
<td>How? Talking to the person concerned, their family, close circle, and other professionals who know them (doctors, facilitators, association members, etc.)</td>
<td>What sources? Work colleagues, multidisciplinary evaluations but also and above all the person concerned. When? From the first contact and throughout the support process. How? By cross-referencing the different points of view, by pinpointing the role and status of each person within their family and society, by discerning obstacles and facilitators, by comparing the characteristics of an individual with the profile of other people in the same context and comparing this analysis with a previous situation.</td>
<td>For whom? For the person concerned, then the other professionals concerned by the situation. When? Following the first interview, then during intermediate results analyses and at the finalization of the support process. How? By referring to the analyses and discussions, by maintaining coherence between what is proposed, the person’s wishes and needs and the objectives to be reached.</td>
</tr>
<tr>
<td>When? During the reception phase and the first interview, then during all future interviews, throughout the support. How? With the help of an interview outline.</td>
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The DCP outline\(^\text{18}\) can then be used to summarise the evaluation of the situation, as it involves most of the personal and contextual elements required for a diagnosis. This summary should then be analysed in order to «understand» the situation. It may also highlight areas to look at in more depth, in order to perform an effective analysis of the situation.

STAGE 3: DEFINING AND NEGOTIATING THE PROJECT

The idea of a project refers to the capacity to project oneself into the future, that is, to look forward and to anticipate what lies ahead. Anticipating the future is based on a philosophical conception of a person who acts on his or her environment in order to achieve their objectives. They will be a player in their personal development or changes in their environment. This position is very different from the fatalistic conception of life (destiny decides our fate) and also requires a sufficiently stable environment to be able to imagine the future. We have noted that it becomes very difficult to make plans if you are ill, or during conflict situations or war.

Developing an approach based on a personalised project in a social facility, for example for children, totally changes the idea of assistance: it is no longer the child that will adapt him or herself to the institutional system but the institution that will provide the child with the resources and

\(^{18}\) Ref annexe “Tool box”
activities they need to develop. As such, the implementation of a personalised project approach within a facility entails an exploration of the institutional project and it is often interesting to be able to perform both simultaneously.

**Basic notions for the project in general: project cycle**

The project cycle is a concept common to social action (or humanitarian) stakeholders and development aid. The first stage, once the situation has been identified, is the initial evaluation. The actions follow a cycle and return to the starting point. When we arrive at this stage, the initial evaluation is often synonymous with the follow-up.

![Project Cycle Diagram]

**Initial evaluation**

The initial evaluation stage corresponds to the collection of information on a given situation. It may be performed at any time (in a crisis situation or otherwise) and provides a perspective on the situation. The initial evaluations produce a “snapshot” of a particular situation, at a precise moment.

**Analysis**

The initial evaluation, without the analysis, is pointless. The analysis therefore gives meaning to the data collected. If it is well done, it offers those performing the actions, tools for understanding the situation in its complexity in order to help take relevant and appropriate decisions.

**Project conception**

The initial evaluation data are used to prepare an objective analysis of the problems with which the populations concerned are faced. Once the problems have been identified, we can enter into the planning of the projects and programmes designed to resolve them.

**Monitoring & evaluation**

The monitoring and evaluation facilitate the collection of information to improve the projects underway. This type of activity forms part of an on-going needs re-evaluation process and gives rise to the opportunity to respond to crisis situations. The monitoring performed by the project personnel seeks to determine if the work of helping people is done correctly and enables activities, the context and the impact of the project to be studied. The evaluation is a project activity which is not only performed by the project personnel. It can take place either in the middle of the project or at the end, or a few years after the end of the project. It seeks to determine if the work performed corresponds to that which was necessary. The monitoring and the evaluation are important activities which enable you to determine if the goals are relevant, realistic/achievable, and if the resources and activities implemented are appropriate.
**Why a project?**
To define a joint objective to be reached. Based on the list of needs, the global and multidisciplinary analysis of the situation and the user’s demand(s), the social adviser proposes subjects to work on and starts outlining a personalised project, to be developed and adjusted with the person him or herself. The responses must reflect the person’s expectations and needs and determine realistic and achievable objectives.

**Drawing up a plan**
- Reviewing the person’s needs and expectations and the responses possible in the given context
- Defining the stages of a personalised project and the resources required to see it through
- Identifying the partners concerned
- Validating the framework for the social support process

Personalised social support should not be considered as a means to define exhaustive objectives for realising a personalised project, but as a way to bring common points and consensus to light for achieving a general goal.

The objective of a personalised project should be **specific** (i.e. unambiguous, and present a unique goal) and **measurable** (i.e. based on concrete facts providing indicators on the progress to make). It should be **realistic** and **feasible**. For example, we cannot talk about a training project if no adapted facilities for providing such training exist in the region or the required resources for following such a training course are unavailable.

The objective should be tied in to a **notion of time**, i.e. it should be realisable within the time-frames accorded. Finally, it should respect individuals, not undermine them, and of course should not condemn a moral code or generate suffering.

According to the issues chosen, objectives can be drawn up in groups: for health, they could include access to functional rehabilitation, an orthopaedic fitting or setting up a psychological consultation; for professional inclusion, drawing up a CV, preparing admission to a training course or an interview with an employer. The objectives are defined by matching up the analyses made during the evaluation phase (the diagnosis/global evaluation stage) and the resources available.

**Practical advice**
- A personalised project forms part of a person’s life project. It will therefore be followed by other personalised projects, which will require, or not, social support.
- It is important to start by defining a key objective, in order to estimate the distance between the point of departure and the point of completion.
- It is advisable to have modest ambitions and ensure that the participant keeps their family, close circle and other parties involved informed on a regular basis.
- The contextual dimension is of critical importance during the development phase of a personalised project. Discussing existing points of influence and stakeholders (family, close circle, other professionals) with the person concerned will help define the actions to take and the resources required.
- Working in association with other stakeholders and partners clarifies the role and responsibilities of each party involved in the personalised project.
- During this negotiation phase, the social adviser must bear in mind their professional remit, i.e. what they can and cannot do (the “services” proposed and their limits).
- Personalised support provided over a period of six months to one year focuses in general on a single issue, or two at the most.
• It is important to remain realistic, i.e. to differentiate between a wish and a need, realism and utopia, and to take into account the particularities of the context and the consequences of the actions under consideration. It would be dangerous to build up hopes for an impossible response or to provoke an imbalance!

In the words of facilitators in the field...
• Cécile de Ryckel, psychologist, Prevention and Health Unit, Handicap International:
  “Choose your words carefully and above all work with the person because setting up the framework can be a delicate process for both parties: the person supported could end up feeling disappointed, showing aggression and the facilitator has to manage the person’s emotional displays and take the risk of being rejected and sinking in the esteem of the person they are supporting. The relationship of trust between the two people partly depends on how this framework is set up at the outset.”

STAGE 4: DEFINING THE ACTION PLAN

Why?
To plan the activities of a personalised project.
Each of the possible responses negotiated with the person concerned requires a specific objective, a division of tasks (who does what), a timeframe and identification of the resources to be used.

How?
• Listing stages, actions and resources
• Programming activities
• Defining the duration of the support process

Each objective must be broken down and matched up to different activities in order to be programmed. For example, if the personalised project concerns a child wishing to practice sport, the action and corresponding activities could be listed as follows:

<table>
<thead>
<tr>
<th>Specific Objective:</th>
<th>Action</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Practicing a sport  | Following an individual rehabilitation plan | • Arranging a medical diagnosis  
  • Follow-up of rehabilitation sessions  
  • Defining possible sporting activities (weigh up desire and capacities) |
|                     | Choosing the sport | • Meeting existing teams  
  • Discussing the disabling situation in order to play it down  
  • Taking part in training sessions |
|                     | Checking the participation conditions | • Evaluating the cost and necessary logistics  
  • Arranging trips to the practice area with the family |
Practical advice

- The majority of actions and activities should be carried out by the person him or herself, with the support of people close to them, of the social adviser and professionals concerned if necessary. The person must be in control and involved in his or her personalised project.
- Each activity should have an action plan, even if adjustments are required later on. The participant needs temporal benchmarks to motivate them, to ensure progress and evaluate the changes, and above all to avoid feeling “abandoned” at the end of the support process.

STAGE 5: CONCLUDING A CONTRACT

Why?
To formalise a reciprocal undertaking with the validation of an oral or written contract.

How?
- Naming the people concerned
- Setting out the subject of the contract, its framework and duration
- Detailing objectives, actions and activities
- Specifying the rights and obligations of each party
- Including possible break clauses

Practical advice

- Being in a social support process with someone obviously entails their agreement to the process. The contract represents this agreement. The will to take part leads to actual participation.
- The contract gives a dimension of equality, thereby avoiding a scenario of protection/assistance. “We both commit to the same course of action”.
- The contract should not limit the person’s participation, and its form must therefore be adapted to the context. It can be validated orally if the oral cultural is more developed than the written one, or if a written document is too intimidating. The main point is that a process of contract takes place at a specified time and place.

STAGE 6: IMPLEMENTING AND MONITORING THE PROJECT

Why?
To support the person in the realisation of their personalised project.

How?
- Providing advice and support to the person in their activities.
- Holding discussions with the partners concerned (social, medical, educational, administrative, other professionals, etc.) and keeping the network alive.

The social adviser coordinates and monitors the project’s different stages. They note the person’s developments during the different stages, help them with any necessary readjustments, provide explanations and give feedback. They take the opinions and reactions of the family and close circle into consideration and regularly consult the other professionals and stakeholders involved.
More generally, when the person has difficulties expressing him or herself, the adviser acts as their “spokes aid” (and not “spokesperson”), representing his or her interests. Finally, they take care to avoid unrealistic aims generating harmful consequences or imbalances. They can propose meetings with partners to this end – a doctor if health is at stake, for example, or a teacher or employer if the project involves the person’s education or job.

Practical advice

- The social adviser’s posture plays a critical role at this stage of the proceedings, contributing to building up the person’s self-reliance and the realisation of their personalised project. So it is of the utmost importance that a social adviser asks regular questions about their practices in order to ensure quality support that achieves their implicit but permanent objectives, which is the capacity to encourage and support the social emancipation of the participant.
- Obviously the participant should not develop dependence on the social adviser and/or social support.
- Building up the person’s self-reliance therefore also relies on the social adviser’s capacity to open the relationship up to third parties, and consider the support in a collective light. There is no need to avoid one-on-one meetings with the person, but they should be placed in a wider context that accords a clear and tangible role to these partners in order to better respond to the needs, possibilities and responsibilities of each party, professional or not.

STAGE 7: INTERMEDIARY RESULTS ANALYSES

Why?
To ensure the relevance of the personalised project.

How?
- Carrying out regular measurements of the discrepancy between objectives fixed at the outset and those attained.
- Readjusting the action plan in order to realise the personalised project in progress.
- Revising the feasibility of the project in progress, which could lead to its interruption, or the negotiation of a new project.

Regular and progressive evaluations of how the personalised social support is unfolding allows both the person concerned and the social adviser to follow the issues being addressed, the distance covered, the capacities improved, the skills developed and any limits identified which may necessitate a revision of the situation. This intermediate evaluation should ideally be carried out once a month, sometimes once every two months. It involves one or several interviews during which the project contract is re-read and discussed together in the light of the identified action and the various activities stemming from it.

The social adviser should keep a personalised file recording all the interview dates, their contents and the recommendations and undertakings made during each one, which will form part of the document summarising the support process.

19. Ref chapter “Role and posture of the social adviser in the social support process”
Practical advice

• The interim evaluation of results should be carried out in accordance with concrete elements of change (including behavioural change) and not in accordance with the general goal to be reached (an effective integration, for example).
  • The evaluation must therefore focus on action carried out by the person in accordance with his or her needs and capacities, rather than in accordance with the problems he or she encounters.
  • It is good practice to advise the person to keep a “log book” in which they can record their remarks, observations and thoughts. This log book could be kept by someone in the person’s close family or the adviser him or herself if no one else can write.
  • The more the person manages their own project and their quest for self-reliance, the less the social adviser needs to be present. The discussions between these two key stakeholders could thus be summarised as moments of intermediary evaluation, with the entirety of the personalised project being realised independently by the person him or herself without the adviser’s presence.

STAGE 8: FINALIZING THE SUPPORT

Why?
To proceed to a results analysis of the support process and propose, if necessary, the next steps.

How?
  • Measuring the objectives fixed and the results achieved
  • Evaluating the impact of the support on the person and their environment
  • Negotiating an exit strategy through the provision of any guidance and follow-up possible, if necessary
  • Evaluating the impact of the project’s realisation 6 months later (approximately)

Support processes are of a limited duration, and this should be specified from the outset and recalled as often as necessary. If necessary, a new project can be negotiated but it will be evaluated on a case by case basis, according to results achieved and its relevance.

Practical advice

• It is important that the supported person receives a summary of all the steps taken and activities carried out. This summary is often the only document in existence testifying to the investment and development of the person in their project. It should refer to all the documents and elements discussed during the support process (diagnoses, action plan, contract, intermediate evaluations, etc.) It is a useful tool for according personal recognition, even if not all the elements it contains are positive. It should refer to both successes and difficulties, in agreement with the supported person.20.
  • The cut-off date should be referred to regularly, without exerting pressure, in order to show the ground already covered and what remains to be done in the time left (which can be re-evaluated in the event of delays beyond the person’s control).
  • As soon as possible, partners should be identified who could provide the person with any guidance and skills he or she asks for/needs at the end of the personalised project.
  • An evaluation of impact at 3 to 6 months (depending on field conditions) should be carried out to measure the project’s quality, but should not be counted as part of the personalised social support timeframe. It should be carried after the personalised social support conclusion.

20.   Ref annexe “Tools for finalizing the support”
ROLE AND POSTURE OF THE SOCIAL FACILITATOR IN THE SOCIAL SUPPORT PROCESS

Social facilitator’s missions

The social facilitator or social adviser is a counsellor, an information-circulator, a coordinator, a manager and a mediator. He or she collects information, evaluates needs, negotiates, informs, raises awareness and guides the supported person, whilst taking into account the family and close circle’s opinions and monitoring their behaviour and attitudes. Whenever necessary, he or she asks the opinion of any colleagues, professionals and external partners involved or simply concerned by the project, depending on the different issues at stake in the social support process (doctors, rehabilitation technicians, professional advisers, other social workers, employer, school director, etc.) He or she participates in maintaining and developing social links, building up contacts at an individual, group or community level and initiating or participating in networks of other professionals who could be involved in the support process at any given moment.

As a reminder, and to draw on the previous chapter covering the specific characteristics of and intervention methodologies applied to each stage of a personalised social support, here is an outline, inspired by the work of Jean-René Loubat, of the main tasks of a social adviser, in association with the stages presented above:

1. Collect information on the situation and needs of the party concerned

2. Processing of information (implement and organise)

3. Presentation of a review of needs identified to other professionals with the potential to provide expertise (medical, social, professional, etc.) and possible solutions

4. Provide information to the person concerned, their family and other partners, collect feedback, define and negotiate a personalised project

5. Follow-up the implementation of the personalised project (remain vigilant, available to the person concerned, and in regular contact with the various stakeholders)

The posture of the social facilitator

Social support implies providing a person with the means to do something him or herself, and above all not doing it for them. This support-based relationship places the supported person at the centre of the action and presents the personalised social support as an ongoing process.

The social support process should remain at the person’s service, not becoming a goal in itself but providing a means to develop or improve a given situation.

Social support is a human-based process, full of emotions, moving moments and interpersonal relationships, with all this entails in terms of dynamics and the issues at stake (recognition, confidence, power, dependence, etc.)

Building a relationship during social support requires awareness and understanding of communicational and behavioural phenomena and psychological reactions that need identification and analysis to avoid emotional dependency.

• Handicap International, Prevention and Health Unit, Mental Health technical adviser:  
  “Support is based on a relationship of empathy, not sympathy. Empathy is a mental attitude involving understanding of the other’s experiences as he or she understands them – but without identifying with his or her suffering. Sympathy, on the other hand, involves this unwholesome type of identification”.

Throughout the personalised social support, the social adviser must always have the general objective in mind, and keep checking that everything happening within his or her relationship with the other corresponds to the realisation of this objective. If this is not the case, he or she is the only one in a position to carry out the necessary readjustments.

Professional readjustments correspond to analysing and developing practices, i.e. the way in which the social adviser enters into relationships with others, conducts interviews and social evaluations and defines objectives. This also concerns their understanding of the suffering and difficulties of the other, drawing on their own experiences and difficulties. This analysis and the adjustments it entails are the keys to maintaining a professional position and not falling into the trap of emotional sympathy, which would reduce the distance necessary for providing effective social support.
Social workers in northern countries should ideally request supervision. Generally carried out with the assistance of a psychologist, supervision\textsuperscript{22} entails holding discussions with social support teams in which they are free to express their feelings about their support missions. The practice of social support can be a source of anxiety for social advisers, leaving them with a sense of isolation, or even powerlessness in certain cases, and thus struggling to maintain their professionalism. Supervision time is therefore set aside to support social advisers in their practice and positioning. It can take place individually or in groups. In the latter case, the participants draw on each others’ experiences to animate the discussion. These moments should be confidential and have no direct operational effect.

\textsuperscript{22} Ref “La supervision d’équipes en Travail Social”, Joseph Rouzel, Dunod, 2007
PREREQUISITES FOR THE DEVELOPMENT OF A SOCIAL SUPPORT SERVICE

The identification of these preconditions paves the way for pinpointing the goals to be reached and values to be enlisted in order to bring about change. It is only once this first phase is completed that services, programmes and institutions can define their range of activities and modes of intervention in detail.

Questions to be addressed before developing a personalised social support service:
Why is social support needed? To achieve what? What are we looking to change or transform? These questions throw light on the position and role of each person (the social adviser and the participant) and explore the direction of and positions assumed in the relationship that has been undertaken.

Who does what? How? With whom and where?
- clarify the opportunities (composition, objectives, responsibilities of each party)
- specify the geographic intervention regions
- identify the “advisers” and check their profile (competences, know-how, limits, etc.)
- formalise discussion times (initial, during results analyses and towards the end)
- coordinate the different facilitators involved with the user (share the diagnosis, definition of roles)

What will all this produce? What will it change? What do we want to evaluate at the end of the support process and/or the project?
- impact on self-reliance, empowerment and participants/users access to rights
- impact on the realisation of a personalised project
- impact on the range of inclusion/services available locally
- impact on practices, collaboration, changes in representations

Reminder: when setting up personalised social support, preliminary knowledge is required on:
- local legislation governing social action (national, devolved or decentralised)
- the intervention area / territory
- the facilities and services (private and/or associative) involved in the social field, how they position themselves and their practical actions developed at local, departmental, regional and national levels
- all stakeholders present in the region in question
- familiarity with and social representation of persons with disabilities amongst these stakeholders
The prerequisite for setting up a social support project also involves (when they exist) the identification and creation of partnerships with groups, conglomerates, federations, institutions, establishments and services, whether public, associative or private. They are then considered as potential partners for carrying out a personalised project, or multidisciplinary platforms to which certain skills or responsibilities can be deferred or transferred.

IMPLEMENTING THE SOCIAL SUPPORT PROCESS: PRACTICAL ADVICE FOR THE FIELD

Once you have identified the target public and stakeholders, understood the situation, and worked out any interrelations, it is possible to consider implementing the social support process. The nature of this process will depend on the level of development of existing services in the area of intervention, the mobilisation of the groups concerned, access to information and the needs expressed. When several resources exist but are not known to the groups in question, a “listening, guidance and information” process can be implemented. This type of process is only designed to meet punctual needs expressed by a person. On the other hand, when people require personalised social support, a specific process will be necessary, with the possibility of including a guidance/information service, if required.

As part of a personalised social support process, the greater the number of existing services/stakeholders, the more a personalised project can be adapted to the needs and wishes of the supported person. If few services/stakeholders exist, the objectives of a personalised project will inevitably focus more on the vulnerable person’s participation in his or her family and community, particularly for persons with disabilities.

A database and/or directory of regional stakeholders facilitate the realistic nature and relevance of personalised projects in the given region and encourage networking efforts amongst the different stakeholders.  

Practical advice:

• The presence of a local information and resource centre has a major impact on the effective implementation of a support service/process, providing knowledge about field stakeholders and the target public.

When a new service is set up, it is important to consider the way in which people will be informed and have access to it.

Social support forms part of a participative, proactive, motivating approach with a mutual commitment from the supporter and, above all, the person supported. In this regard, the person is encouraged to search for information and to take part of their own accord in the support mechanism, as a prerequisite to the support approach. In parallel to this mechanism, information sessions and focal points/outreach services will be set up and foster access to the social support mechanism.

Depending on the situation, such an approach would work for people in need of “information/guidance”, but not necessarily for the most vulnerable, who have a real need for social support. We can therefore, in this case, encourage the presence of community workers, offering outreach information (identification) to the most isolated individuals and guiding them towards the support mechanism.

Lastly, when local perceptions of disability are not favourable to the empowerment approach, it is essential, at the same time, to hold sessions designed to raise the awareness of the situation of persons with disabilities at community level, in order to give a sense of responsibility to all local stakeholders and to promote real social change in relation to disability. If personalised social support is used in field programmes, the following evaluation criteria must be measured, before the project starts and throughout its implementation:

Criteria concerning local stakeholders

• What are the local public and/or association and/or private structures present in the region? What is the analysis of stakeholders? How does this analysis compare to the same analysis carried out before the project started (as a precondition) and then later on?
• What are the developments in the stakeholders’ capacities to deal with persons with disabilities?
• Are the professionals present familiar with personalised social support?
• Do they have the time and resources to be involved in such a process?
• What is the role/scope of the social inclusion of persons with disabilities in the region?
• Are there social advisers or other persons who take on this function?
• Are there local forums for discussion, reflection and decision-making on disability and inclusion?
Criteria concerning the user

• How many personalised projects have been realised?
• Satisfaction questionnaire: what do the users say?
• Participation criteria: is the person involved in all the support stages? Is the support process fully participative?

Criteria concerning external partners

• What partners are involved or associated with existing personalised projects?
• Do they meet amongst themselves, and if so, with what regularity?
• How is the mechanism involved in these meetings?
• Is a link formed between the partners?

PROFILE OF A SOCIAL FACILITATOR / ADVISER

A social adviser’s task is to draw on the entirety of his or her knowledge (human and relationship skills/abilities) and know-how (technical skills).

Here is an example of job profile which could facilitate the recruitment process of social facilitators and advisers.

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**JOB PROFILE OF A SOCIAL ADVISER**

**DEFINITION OF THE POST**

The social adviser provides preventive measures and treatment of personal and collective problems by listening, helping, monitoring and advising individuals and groups. Acting within his or her social role, they set up the necessary mediation between persons and groups and their personal environment, and with any institutions or partners concerned.

**KEY ACTIVITIES**

• Informing on existing mechanisms, rights and services;
• Holding meetings with people to examine their circumstances and draw up a general overview of their social, personal and professional situation;
• Looking for ways to resolve problems/meet demands by using all appropriate means – individual and/or collective - available;
• Monitoring the persons and evaluating developments in their situation;
• Encouraging the self-reliance of the individuals in question;
• Leading/participating in awareness-raising activities or training sessions focusing on individual and/or community social issues;
• Providing mediation with the environment (families, communities, other services, etc.)

**TECHNICAL COMPETENCES AND KNOW-HOW (being capable of)**

• Conducting individual and/or collective interviews, (mastery of interview techniques);
• Identifying the disparities, dysfunctions and obstacles;
• Carrying out a social diagnosis;
• Co-building a personalised project, based on the person’s demand and the diagnosis made of the situation;

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• Creating a professional relationship built on trust and individual assumptions of responsibilities;
• Coordinating and working as a team on a shared project;
• Setting up and leading meetings and ensuring things move forward.

KNOWING HOW TO BE (abilities)
• Tolerant and respectful
• Discreet
• Capable of listening, with a will to understand
• Empathetic and not sympathetic\(^{25}\)
• Rigorous/flexible: socially adaptable/adapted
• Available
• Has a humanist approach
• Rational, works on a realistic basis

ASSOCIATED KNOWLEDGE
• Knowledge of psychology and sociology (how human psychology functions, relationships between social groups, etc.);
• Anthropological knowledge of a country and target group (history, culture, traditions, beliefs, etc.);
• Knowledge of the particularities of a target group (for HI, knowledge of tools adapted to persons with disabilities, etc.);
• Knowledge of different support and care-management mechanisms for the target public;
• Knowledge of stakeholders and regional and national services (who? what? how? where?);
• Knowledge of national and international legislation, adapted to the target public.

The interpersonal and technical skills mentioned are not exhaustive and are acquired and perfected with time and experience. They are the fruit of a social facilitator's learning curve, and are shaped by his or her field practice and the readjustments\(^{26}\) it constantly requires in accordance with the circumstances, contexts and particularities of each situation, personal life history and the individual involved.

Practical advice:
• With regards to various support missions targeting Handicap International's social facilitator teams, it is clear that they lack time to share their experiences and “unwind”, an opportunity often only offered following ad hoc crises. It is important, in order to optimise your professional and personal positioning, to implement supervision time from the start of the project/social support service.
• This activity should ideally be coordinated by a psychologist external to the project/service, or else the team manager. In this case, this would be called practice exchange time.
• Ensure social advisers benefit from training\(^{27}\) and skills in relation to the target public, and complete this with practice-based exchanges and supervision, by reviewing case studies, for example.

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\(^{25}\) Refer to “Role and posture of the social facilitator in the social support process”, p. 40
\(^{26}\) Ref “the Posture of the social facilitator”, p. 41
\(^{27}\) We have chosen not to address the issue of training for social advisers in depth here, despite it’s central importance, for reasons of space. A module on the training of social advisers, based on this guide, will be available in 2010.
Toolbox

► Stage 1: Initial contact  PAGE 50
► Stage 2: Diagnosing the situation  PAGE 51
► Stages 3 and 4: Defining, negotiating and planning the project  PAGE 65
► Stage 5: Concluding a contract  PAGE 67
► Stage 6: Implementing and monitoring the project  PAGE 69
► Stage 7: Intermediary results analyses  PAGE 70
► Stage 8: Finalizing the support  PAGE 71

The tools referred to here mostly come from projects developed by Handicap International's teams and their partners in numerous countries. A sample range of tools is presented here, in order to illustrate the various personalised social support stages.

The tools discussed below were developed in specific situations. It is therefore necessary to adapt them to the needs and realities in the field by taking into consideration cultural, political, social and economic particularities.

Lastly, please refer to the CDROM accompanying this guide for an exhaustive insight into the tools produced by the various Handicap International teams.
Stage 1: Initial contact

Reception sheet / initial contact (example HI, France programme, ICOM)

Date: Received by: Photo

Participant reception

IDENTIFICATION

Name: ________________________________________________________________
Surname: ______________________________________________________________
Address: ______________________________________________________________
________________________________________________________________________
________________________________________________________________________
Contact: ____________________________
Date of birth: _____________________
Place of living:  □ Family  □ Apartment  □ Specialised environment  □ Other: _________
Place of daily activity: __________________________________________________
Legal representative (responsible): __________________________________________
□ Parents (specify relation/link with representative if not parents)  □ Tutors  □ Establishments
Address: ______________________________________________________________
________________________________________________________________________
________________________________________________________________________

Expressed needs/nature of request: _________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
The “Disability Creation Process” presented in this guide offers a model for analysing participation or social exclusion situations. This model can be adapted to the situation facing each individual by creating a questionnaire as a basis for the collection and analysis of information on life habits / activities of daily living, and personal and environmental factors.

### Stage 2: Diagnosing the situation

#### Life habits recorded by the DCP

<table>
<thead>
<tr>
<th>Life habits</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>Diet, food preparation, meal taking</td>
</tr>
<tr>
<td>Body condition</td>
<td>Rest, physical condition, mental condition</td>
</tr>
<tr>
<td>Personal care</td>
<td>Body care, excretal hygiene, clothing, health care</td>
</tr>
<tr>
<td>Communication</td>
<td>Oral and body communication, written communication, telecommunication, signs</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Choice of and adjustments to accommodation, household maintenance, use of furnishings and other domestic equipment</td>
</tr>
<tr>
<td>Journeys</td>
<td>Restricted journeys, transport</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>Financial responsibilities, civil responsibilities, family responsibilities</td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td>Sexual, emotional and social relationships</td>
</tr>
<tr>
<td>Community life</td>
<td>Association-based life, spiritual and religious life</td>
</tr>
<tr>
<td>Education</td>
<td>Preschool/school/professional education, other training</td>
</tr>
<tr>
<td>Work</td>
<td>Professional guidance, job seeking, paid work, unpaid work</td>
</tr>
<tr>
<td>Leisure</td>
<td>Sport and games, arts and culture, socio-recreational activities</td>
</tr>
<tr>
<td>Other practices</td>
<td>Practices that cannot be placed in the above categories</td>
</tr>
</tbody>
</table>

#### Personal factors

**Organic system**

1- Nervous system
2- Auricular system
3- Ocular system
4- Digestive system
5- Respiratory system
6- Cardiovascular system
7- Haematopoietic and immunity system
8- Urinary system
9- Endocrine system
10- Reproductive system
11- Cutaneous system
12- Muscular system
13- Skeletal system
14- Morphology

**Abilities**

1- Intellectual activity-related abilities
2- Language-related abilities
3- Behaviour-related abilities
4- Senses and perception-related abilities
5- Physical activity-related abilities
6- Breathing-related abilities
7- Digestion-related abilities
8- Excretion-related abilities
9- Reproduction-related abilities
10- Protection and assistance-related abilities

#### Environmental factors

**Social factors**

Politico-economic factors (ex : family income, social protection, etc.)

Politico-cultural factors (ex : caregiver, attitudes of community towards disability, etc.)

**Physical factors**

Nature (ex : proximity of services/businesses, etc.)

Adjustments (ex : accessibility of infrastructures, etc.)
The box below may be used to collect information on a complete range of a person’s factors and life habits, once contact has been made and with the aim of producing a global portrait based on an initial questionnaire. It can be used during the process with regards to a life habit forming part of the person’s personalised project, as a basis for a more specific analysis of related factors.

Example 1, data collection/analysis, based on the DCP model (example taken from a training organised by the GIFFOCH)

<table>
<thead>
<tr>
<th>Cause/risks</th>
<th>Environmental factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal factors</td>
<td></td>
</tr>
<tr>
<td>Life habit(s) / activitie(s) of daily living</td>
<td></td>
</tr>
</tbody>
</table>

Do not forget to add information on the identity of the person and on the person’s situation at the bottom of the page:

Surname: _________________________ First names: _________________________
Contact details: _________________________ Age: _________________________
Family situation: _________________________ Number of children under their care: ______
Profession: _________________________ Education: _________________________
Professional incomes: _________________________ Other allowances: _________________________
The following example is based on the Disability Creation Process model, and can be used also for diagnosing the situation.

### Example 2, individual form / initial data collection (example HI, Indonesia programme)

| DATE: ____________________________ |
| NAME OF COMMUNITY DISABILITY WORKER: ________________________________ |
| PLACE OF ASSESSMENT: □ in home □ in social center □ other ________________________________ |

### PERSONAL DATA

| PATIENT NAME: ____________________________________________ |
| AGE: __________________________ |
| GENDER: ______________________ |
| PARENTS NAME (if under 16): __________________________________ |
| STATUS (Married or not): ____________________________________ |
| ADDRESS: ________________________________________________ |
| ____________________________________________________________ |
| ____________________________________________________________ |
| CONTACT TELEPHONE NUMBER: ________________________________ |

### HEALTH

Medical history (hospitalizations, birth complications, accident, fractures, treatments to date, past and present health issues, etc.): ________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Physical impairment □ YES □ NO
Description (can’t walk because can’t move legs, has pain, etc.): __________________________

Sensorial impairment □ YES □ NO
Description (blind, deaf, etc.): ____________________________________________________________

Intellectual impairment □ YES □ NO
Description: ____________________________________________________________

Mental illness □ YES □ NO
Description: ____________________________________________________________
**ENVIRONMENT**

**SOCIAL**
- Number of people in the house and relationships: __________________________________________

- Sexual and affective life: ____________________________________________________________

- Main caregiver if needs (specify when, for what): _____________________________________

- Links with neighbours / community members: _________________________________________

**ECONOMICAL**
- Main source of revenue (who and what livelihood activity): ____________________________

- PwD has access to social protection services: □ YES □ NO

- Other: __________________________________________________________________________

- Economic status: □ Poor □ Moderate □ Comfortable

**PHYSICAL**
- House description (on steel, level, wooden, concrete): _________________________________

- Access to the house from the street (concrete, sand path, stones): ______________________

- Presence of steps/stairs outside and inside the daily living environment /house: __________________

- Material of floor surface: __________________________________________________________

- Situation of the house (in relation with the community): ________________________________

- Proximity of services (health center, school, community center, leisure, church, etc.): ______

**OCCUPATION**

**EDUCATION**
- Education level, ongoing studies / trainings: __________________________________________

- (If kid) Is the person going to school? □ YES □ NO

- Details: _________________________________________________________________________

**LEISURES (community activity, sports, etc.)**
- Description of the PWDs social activities: ___________________________________________

- Is the person satisfied with his/her present activities? □ YES □ NO

- Explain: _________________________________________________________________________
LIVELIHOOD

Is the person working? □ YES □ NO
Explain: ________________________________________________________________

Employment history: ______________________________________________________

Has the person ever received trainings? □ YES □ NO
Other skills: ________________________________________________________________
Interests: ________________________________________________________________

ACTIVITIES OF DAILY LIVING

MOBILITY

• Walking indoors □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

If unable to walk: □ carried □ wheelchair □ Rolling/crawling or other

• Go to the bathroom □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

• Go to the kitchen □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

• Go to the living room □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

• Go to bedroom □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

• Walking outdoors □ Able alone □ Able with help □ Unable
Explain: ________________________________________________________________

If unable to walk: □ Able alone □ Able with help □ Unable
Access to which transportation for longer distances (bus, motorcycle, car): ___________
Places in community that are not accessible to him/her (market, puskesmas, public buildings, mosq, etc.):

PRAYING: ________________________________________________________________
SELF CARE

• Use the toilet
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• Bathing
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• Dressing
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• Eating / drinking
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

DOMESTIC ACTIVITIES

• Food preparation
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• House cleaning
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• Washing clothes
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

• Washing dishes
  □ Able alone □ Able with help □ Unable

Explain: ____________________________________________________________

***

Problems identified by the person / expectations: ______________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Other comment / remark: ____________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
Other types of questionnaires are designed, from the data collection stage, to provide the basis for strategies for the development of a personalised project, as illustrated by the following extract:

Example 3, Individual form / initial data collection (example HI, Nepal programme, extract from a questionnaire)

<table>
<thead>
<tr>
<th>Name of the organization: __________________</th>
<th>Name of the CDW: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program District: ___________________________</td>
<td>Assessment Date: ______________________________</td>
</tr>
<tr>
<td>How did the individual came into contact? _________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

1. General Information

1.1. Name of Person: _____________________ Age: _______ Sex: F □  M □

1.2. Marital status: □ married □ un married nb. of children: _______________________

1.3. Guardian’s Name: _____________ Relation to the PwD: _______ Occupation: ___________

1.4. Caretaker’s Name: _____________ Relation to the PwD: _______ Occupation: ___________

1.5. Address: __________________________

District: ___________________________ VDC/ Municipality: ___________________________

Ward no: ___________________ Tole: _______________ Phone number(s): __________________

2. History of the Person

2.1. Identification of the main difficulty

2.1.1. What is your main difficulty? ________________________________________________

2.2. Identification of the possible causes of the disability

2.2.1. When and how did the difficulty start?

☐ birth      If yes, was there any problem: ☐ during pregnancy  ☐ during delivery

☐ illness, please specify: ____________________________ date: _______________________

☐ accident, please specify: ____________________________ date: _______________________

☐ malnutrition/lack of vitamin A      ☐ related to the conflict, please specify: _______________________

☐ other, please specify: ____________________________

2.2.2. Over time, has your difficulty: ☐ stayed the same  ☐ improved

☐ worsened, please describe _______________________

2.2.3. Do any other family members/relatives have a disability?  ☐ no  ☐ yes, please specify: ____

2.3. Type of support sought:

2.3.1. Were you able to do anything to overcome the difficulty?

☐ No, why:  ☐ fear/ hesitation  ☐ don’t know whom to contact  ☐ too expensive

☐ not available  ☐ not a priority  ☐ other, please specify: _______________________

☐ Yes, where:  ☐ local traditional healer  ☐ health post  ☐ hospital  ☐ local organisation

☐ other, please specify: ____________________________

If yes, what was the result?  ☐ improvement  ☐ no change  ☐ situation worsened
### 3.1 Social Empowerment

<table>
<thead>
<tr>
<th>STATUS</th>
<th>VISION/ GOAL</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| **Personal talents, education and vocational skills** (Personal skills)  
What are you good at? What are your talents/skills?  
What do people like about you (personality or skill)? | What skills/talents would you like to improve on? | Investigate possible links with community  
ie. If good at art, link with someone in the village that likes art, if good at weaving, investigate possible employment/volunteer opportunities. Link with whatever opportunities that promote confidence, interaction & participation. |
| **Participation in the family life**  
How do you participate in your family activities?  
☑ attends family functions  
☑ contributes to domestic chores  
☑ involved in family decision making/discussion  
☑ No participation  
Does your family support you to participate?  
☑ no ☐ If yes - what type of support: | Would s/he like to participate in other tasks?  
Would the PwD like to participate more in the life of the family? Where could s/he get more involved?  
What are the possible obstacles? How can they be overcome? | Counselling, encourage family to increase opportunities for participation, modelling. |
| **Participation in the social life of the community: Community groups:**  
Do you currently attend community groups?  
☑ yes ☐ Disabled Person’s Organisation  
☑ Co-operative ☐ child club ☐ Forest user group  
☑ Women’s group ☐ other, which one(s):  
☑ no ☑ attended in the past, reason for stopping:  
If yes, what is your level of participation:  
☑ physically attend ☑ contribute to activities/discussions ☑ involved in decision making ☑  
Are you satisfied with this level of participation?  
☑ yes, what do you like?  
☑ no, why? | What would you like to do (school/ community group)?  
If you are attending school/work/comm.. group, how could your participation level increase? | Link with local school, leisure activities, work opportunities/DPO’s or self help groups, other community groups, investigate volunteer opportunities. |
| **Communication:**  
**Communication skills of the person:**  
How do you communicate?  
☐ Speech ☐ Sign Language  
☐ Gesture ☐ Visual aids  
Who understands what you say?  
Who do you feel most comfortable communicating with?  
Are you frustrated/ angry if there are things you would like to say but don’t manage to communicate?  
☑ yes ☐ no | When or where would you like to communicate?  
What’s stopping you from communicating now? | Why function is affected:  
☐ Physical ☐ Social ☐ Intellectual  
☐ Access to language/communication  
*Explain how: ie. Stroke, lacks confidence to speak, no access to learn sign language, limited vocab*  
How can you support the family to give messages? Visual aids, gesture, sign language, simple sentences.  
*Referral to specialised services or DPO for sign language development/ development of visual aids such as communication book, speech therapy if available, hearing aid, Link other families or role models if relevant/available.* |
| **Communication within the family:**  
How do you communicate with people in your family? (Questions to the family)  
Do you interact/talk with the person:  
☑ as often as with other family members ☐ more often ☐ less often  
Do you understand what the person means?  
☐ never ☐ sometimes ☐ most of the time  
☐ all the time  
Does the person understand you?  
☑ never ☐ sometimes ☐ most of the time ☐ all the time  
Are there particular barriers for communication within the family?  
What are 3 messages you would like to tell your family?  
How could communication within your family improve?  
What are 3 messages you would like to tell your child/family member? | | |

---

28. Extract of questionnaire only, refer to CD-rom “resource kit on personalised social support” for complete form
<table>
<thead>
<tr>
<th>Communication with the community:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Questions to the person and/or family)</em></td>
</tr>
<tr>
<td>Are you satisfied with the level of communication between you and community members?</td>
</tr>
<tr>
<td>□ never □ sometimes □ most of the time</td>
</tr>
<tr>
<td>□ all the time</td>
</tr>
<tr>
<td>How could communication improve between you and the community?</td>
</tr>
<tr>
<td>What modes of interaction can be developed/ encouraged?</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Communication with the community:</th>
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<tr>
<td>□ never □ sometimes □ most of the time</td>
</tr>
<tr>
<td>□ all the time</td>
</tr>
<tr>
<td>How could communication improve between you and the community?</td>
</tr>
<tr>
<td>What modes of interaction can be developed/ encouraged?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude and perception</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-perception</strong> <em>(Self-confidence, self-image, self-acceptance)</em></td>
</tr>
<tr>
<td>How happy are you with your life?</td>
</tr>
<tr>
<td>□ not happy at all □ not happy on some aspects □ ok □ happy □ very happy</td>
</tr>
<tr>
<td>Do you feel comfortable to tell people what you think/ feel/need?</td>
</tr>
<tr>
<td>□ yes □ If no why?</td>
</tr>
<tr>
<td>Do you undertake action/ do things from your own initiative?</td>
</tr>
<tr>
<td>□ yes □ no</td>
</tr>
<tr>
<td>Are you frustrated/ angry about things you would like to do but cannot?</td>
</tr>
<tr>
<td>□ yes, what □ no</td>
</tr>
<tr>
<td>How would you like to see yourself? What would help you to feel more satisfied/happy/confident?</td>
</tr>
<tr>
<td>What can be done to improve the self image and confidence of the PwD?</td>
</tr>
<tr>
<td>Links with others, self help groups, DPO’s, role models, improve networks/supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude of the family towards the person:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(As perceived by the person)</em></td>
</tr>
<tr>
<td>Do you feel important to your family?</td>
</tr>
<tr>
<td>□ yes □ no  Why?</td>
</tr>
<tr>
<td>Does your family ask for or respect your opinion?</td>
</tr>
<tr>
<td>□ yes □ sometimes □ no  Why?</td>
</tr>
<tr>
<td><em>(Questions to the family)</em></td>
</tr>
<tr>
<td>How do you call the PwD/ any special nickname?</td>
</tr>
<tr>
<td>Do you think the person is valued, appreciated and understood by everyone in your family?</td>
</tr>
<tr>
<td>How would you like your family to see or treat you?</td>
</tr>
<tr>
<td>How could your relationship with your family improve?</td>
</tr>
<tr>
<td>Where do you picture your child/relative in 5 or 10 year’s time?</td>
</tr>
<tr>
<td>Links with other families, self help groups, DPO’s, role models, improve networks/ supports, counselling/education re: equal value &amp; rights of person.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude of the community:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(As perceived by the community)</em></td>
</tr>
<tr>
<td>How are you referred to in the community?</td>
</tr>
<tr>
<td>How would you like the community to see/treat you?</td>
</tr>
<tr>
<td>What can be done to increase connections/ friendships and respect with community members?</td>
</tr>
<tr>
<td>Support links with key community members, community groups, identify where social communication could assist attitude change.</td>
</tr>
</tbody>
</table>
Lastly, other tools may be developed according to the context of the support process, in association with the people and resources in place.

Example 4, individual sheet/initial data collection (example HI, Morocco programme)

I/ ADMINISTRATIVE INFORMATION (concerning the user)
SURNAME and First names: ____________________________________________
Born on: ____________ at: ____________________________
Nationality: ___________________ Address: ____________________________
Mutual insurance company and No.: ____________________________
Other Insurance: □ yes □ no
If yes, contact details of insurance company: ____________________________
________________________________________________________________________

II/ FAMILY SITUATION*
□ Married □ Widowed □ Single □ Divorced □ Cohabitating
Since ________ Since ________ Since ________ Since ________
Do you have any children? If yes, how many? ____________________________
How old are they? ____________________________
Do you have custody of the children? ____________________________
Do you have family or emotional ties with parents - partner - children - friend(s).
(*Cross out those that do not apply)

III/ INFORMATION ABOUT THE FAMILY

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>FATHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>First name:</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>Family situation</td>
<td></td>
</tr>
<tr>
<td>- Married</td>
<td></td>
</tr>
<tr>
<td>- Divorced</td>
<td></td>
</tr>
<tr>
<td>- Separated</td>
<td></td>
</tr>
<tr>
<td>- Widowed</td>
<td></td>
</tr>
<tr>
<td>Professional situation</td>
<td></td>
</tr>
<tr>
<td>- In active employment</td>
<td></td>
</tr>
<tr>
<td>- Retired</td>
<td></td>
</tr>
<tr>
<td>- Job seeker</td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td></td>
</tr>
<tr>
<td>If active, specify:</td>
<td></td>
</tr>
<tr>
<td>Siblings (names, first names, dates of birth):</td>
<td></td>
</tr>
</tbody>
</table>
* Particular situation
- blended family □
- siblings including other disabled children: □

This admission is requested by the user: □ yes □ no
This admission is required by a third party: □ yes □ no
This admission is required by the family: □ yes □ no

IV/ INFORMATION ABOUT THE DISABILITY

Type of disability:
- physical impairment □
- mental impairment □
- sensorial impairment □
- associated disorders □
Details, if appropriate: ____________________________________________________________

Origin of disability:
- Perinatal □
- Natal □
- Postnatal □
- Others:
Details, if appropriate: ____________________________________________________________

If it relates to an accident, please specify:
Work accident (excluding travel) ____________________________________________________
Road accident _________________________________________________________________
Sporting injury _________________________________________________________________
Suicide attempt ________________________________________________________________
Domestic accident ______________________________________________________________
Aggression _______________________________________________________________________
Accident during a professional trip ________________________________________________
Others, please specify: __________________________________________________________

If it relates to an illness:
Active disease □
Inactive disease □
Others, please specify: __________________________________________________________

Regular doctor Specialism
NAME: ____________________ NAME: ____________________
Address: __________________ Address: __________________
Tel.: ______________________ Tel.: __________________
Fax.: ______________________ Fax.: __________________

Specialist doctors who provide/provided follow-up care (including psychiatrists)

NAME: ____________________ NAME: ____________________
Address: __________________ Address: __________________
Tel.: ______________________ Tel.: __________________
Fax.: ______________________ Fax.: __________________
VACCINATION

- Hepatitis □ yes □ no Date: ____________________________
- BCG □ yes □ no Date: ____________________________
- DTP □ yes □ no Date: ____________________________

DEPENDANCES

Tobacco, drug □ yes □ no

Please specify:

Allergies □ yes □ no Specify: ____________________________
Respiratory problems □ yes □ no
Diabetes □ yes □ no
Epilepsy □ yes □ no Type: ____________________________
Frequency: ____________________________

Cardiovascular disease □ yes □ no
Surgical operation □ yes □ no Nature and date(s): ____________________________

Contra-indications to certain positions □ yes □ no

Enuresis □ yes □ no
Incontinence □ yes □ no
Treatment □ yes □ no
Is it managed by the user □ yes □ no
If yes, how? _____________________________________

V/ SOCIAL LIFE

Background of the care-management and/or support situations (specify age at each stage):

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

VI/ AUTONOMY

Specify your degree of autonomy

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need help getting up and lying down?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help at night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help washing yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you use a bath?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help using a shower?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a specially-adapted shower?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the toilet specially adapted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help dressing yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help preparing your meals? Specify if partial or total help?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you need help eating meals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help with administrative tasks?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Specify your degree of autonomy**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need help preventing sores?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help with your natural needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help getting into a wheelchair?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you follow a specific diet? If yes, which one?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help shopping?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need support for outings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need transport help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help preparing medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help taking medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you use your telephone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>False problems handling the telephone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>impossible to use without the help of a third party?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you open/close the doors of your home alone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you move around alone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On foot</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>By train</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>By bus</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have a motorised form of transport?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**VII/ SCHOOLING- SPECIALISED ESTABLISHMENTS**

Level of education: ________________________________

Dates: ____________________________________________

Contact details of the establishment: ____________________________

Establishment(s) attended:

<table>
<thead>
<tr>
<th>Establishment(s) attended</th>
<th>Dates</th>
<th>Dates</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VIII/ LEVEL ATTAINED**

Does he/she know how to...?

<table>
<thead>
<tr>
<th>Ability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete tasks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IX/ PROFESSION EXERCISED**

Currently: ________________________________

Prior to disability: ________________________________

---

**Toolbox**
**XI/ LEISURE AND TRAVEL**

Can he/she spend a leisure day alone? Specify: _______________________________________
Preferred leisure and activities: __________________________________________________________
________________________________________________________________________________________

**XII/ BEHAVIOUR**

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quiet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhibited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exuberant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other deviant behaviour
If yes, specify: __________________________________________________________
________________________________________________________________________________________

**XIII/ SOCIABILITY**

<table>
<thead>
<tr>
<th>Sociability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With friends (if establishment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff (if establishment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**USER NEEDS**

EXPECTATIONS AS EXPRESSED BY USER: __________________________________________________________
________________________________________________________________________________________

The professional meeting the user:
Name: __________________________________________________________
First name: ______________________________________________________
Position: ________________________________________________________
Date: ____________________________________________________________ Signature
These stages, which follow the social diagnosis, focus on the needs expressed by the person, and the elements gathered at an individual and an environmental level. These stages are crucial and should be participative in order to identify precise objectives and resources, and to facilitate the involvement and follow-up of the parties concerned. The tool featured below also includes the next stage – concluding the contract.

**Negotiation of the personalised project/action plan (HI example, Morocco programme)**

**Social participation support programme**

**PERSONALISED ACTION PLAN**

Date of Life Project development meeting: _______________________________________
Participants: _________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**IDENTIFICATION OF USER**

Surname: ___________________________ First name: _____________________________
Date and place of birth:______________________________
Gender: female □ male □
Current address: ___________________________________________________________

**IDENTIFICATION OF ADVISING PROFESSIONAL**

Surname: ___________________________ First name: _____________________________
Position: ___________________________________________________________________
Date of life project implementation: ___________________________________________

**EXPECTATIONS AS EXPRESSED BY USER:**

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**ANALYSIS:**

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
# Follow-up and Evaluation of Actions

## Planning of Goals

In order of priority, identify the goals to attain which are associated with the needs of the person and their family and the services required.

<table>
<thead>
<tr>
<th>Goals to attain</th>
<th>Resources to implement</th>
<th>Establishment or organisation responsible</th>
<th>Scheduled completion date</th>
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## Decisions Made at the End of the Meeting

Determine by goal the required alternative measures, their frequency, type of organisation or service provider and scheduled completion dates.

<table>
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<tr>
<th>Service supplied</th>
<th>Establishment or organisation responsible</th>
<th>Prior steps required</th>
<th>Start date of provision</th>
<th>Date put on hold</th>
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## Planning of Alternative Measures to Be Taken When Services and Resources Are Unavailable

I confirm that I have read the contents of my personalised action plan and I consent to receive the services proposed to me, as agreed between the parties.

Signed at ____________________________
On ________________________________
Social support contract (example of the Jacques Arnaud centre in Bouffémont, France)

Between the undersigned parties:
The ________________ association represented by ________________ director/head of service, project manager, social facilitator

And Mr / Mrs / Miss__________________ domiciled/resident at __________________________________

Subject of the contract:
This contract sets out the conditions for the personalised social support process.

This forms part of the identification, guidance and follow-up system for persons with disabilities and aims to optimise their participation and social inclusion.

This social support is entrusted to _____________________ Position____________

Intervention goals:
The goal is to support the person with disabilities in their actions as soon as they take part in the support process.

In order to do this, personalised social support is offered by an adviser who, in agreement with you, will set out the key stages to:

- understand and analyse your situation
- negotiate a personalised action plan
- follow-up and provide advice during the process
- perform regular reviews of goal attainment
- identify the prospects for preparing to exit the process

This support is provided through regular contacts:
- at least once a month
- then every time it is deemed necessary

Goals selected, their names, and the steps and resources to implement are specified below:

1. ____________________________________________________________
   
2. ____________________________________________________________
   
3. ____________________________________________________________
**Mutual commitments:**
Mr/Mrs/Miss ________________________ agree(s) to accept the social support offered, and to do everything possible to achieve the goals as defined in the project:
- respect the meetings arranged and give notice of inability to attend
- accept to receive the adviser at home
- take the necessary steps to achieve the goals.

The association ____________________ agrees to provide the services proposed as part of the social support process in compliance with the set of specifications applied within the framework of the project.

In order to do this, the adviser agrees to:
- perform home visits;
- receive you at the association's offices;
- keep in regular contact with partners;
- create a link with the various services concerned (social services, training organisations, guidance or inclusion, etc).
- perform regular evaluations.

**Duration of the contract:**
This contract takes effect on ______________ for an initial period of three months, following which a report will be drawn up with the person with disabilities in order to ensure the relevance of extending or terminating the process.

**Contract termination conditions:**
Breach of this contract will result in the early termination of the social support.
Mr/Mrs/Miss ________________________ may request the early termination of the social support at any time by providing notice to the social adviser. A care-management completion report will be drawn up and addressed to the user and to the services in question.

Produced in duplicate at ____________________, on ________________.

Mr/Mrs/Miss
(Name, Signature)__________________________________________

For the association
(Name, position, signature)_________________________________*
STAGE 6: Implementing and monitoring the project

Follow-up sheet (example HI, Nepal programme)

Name: ___________________________________________ First name: _________________________________
Community disability worker: _______________________

<table>
<thead>
<tr>
<th>Visit no.</th>
<th>Date</th>
<th>Activity</th>
<th>Plan/goals/activities for follow-up visit</th>
<th>Observations, changes (if applicable)</th>
<th>Specific support provided</th>
<th>Comments, recommendations</th>
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Other observations/comments/current steps:

Signature and date: ____________________________________________________________
### Recap of project

**Project name:**

**Period concerned:** from ____ / ____ / ____ to ____ / ____ / ____

**Initial goals:**

1. 
2. 
3. 

### Work performed

<table>
<thead>
<tr>
<th>Issues</th>
<th>Underway</th>
<th>Attained</th>
<th>Remaining</th>
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</thead>
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<tr>
<th>Remarks</th>
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- **Problems encountered:**
  - By the person ________________________________________________
  - By the social adviser/worker ________________________________________

<table>
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<tr>
<th>Future recommendations:</th>
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Completed on ____________ at ____________ by ________________________
### Support summary
*(example taken from the Jacques Arnaud centre, France, adapted for HI, Algeria programme)*

#### PERSONAL DATA
- **NAME:** __________________________
- **Addressed by:** ______________________
- **First name:** ________________________
- **Address:** ___________________________________________________________________
- **Disability Card No. (if necessary):** ____________________________________________
- **Telephone:** ________________________
- **Date and place of birth:** _________________________________________________________
- **Family situation:** _____________________________
- **Means of transport/driving licence:** ____________________________________________

#### POSITIONING STAGE
- **Action initiation project:** _______________________________________________________

#### PERSONAL REPORT:
- **At a personal level:**
  - Describes self as: _____________________________________________________________
- **Training:**
  - Primary schooling: ___________________________________________________________
  - Secondary schooling: _________________________________________________________
  - Languages studied: ___________________________________________________________
  - Professional training: _________________________________________________________
Professional experience:
  Internships completed:  
  Jobs held:  

Extra-professional activities:  

Work conditions:  

Motivation and centres of interest:  

MEDICAL REPORT
+ individual sheet/information reports

MATURATION PROCESS

= Relationships/development of the participant in the support process. Intermediary points

Activity 1:  
Activity dates: from _____ / _____ / _____ to _____ / _____ / _____
Activity manager:  
Adviser:  
Goal:  

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<tr>
<th>Task entrusted with</th>
<th>Tools used</th>
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<tr>
<th>Tasks not entrusted with</th>
<th>Reasons</th>
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</table>
### Activity report 1:

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<tr>
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<th>Adviser or partner</th>
<th>Participant</th>
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<tbody>
<tr>
<td><strong>Strong points</strong></td>
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<tr>
<td><strong>Problems encountered</strong></td>
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<td><strong>Areas for improvement</strong></td>
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<tr>
<td><strong>Conclusion</strong></td>
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**CONCLUSION/PROPOSAL OF THE TEAM**

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- 
- 
- 
- 

**DECISION OF THE PARTICIPANT**

- 
- 
- 
- 
- 

On ______________________________ at ______________________________

Signatures:
- Participant
- Social adviser/worker
- Coordinator/team leader/project manager

**Activity 2, 3, etc.**
• FONDEMENT DE LA PRATIQUE DE L’APPROCHE SYSTEMIQUE EN TRAVAIL SOCIAL
MASSA, Hélène,
Les cahiers de l’actif n°308/309, www.actif-online.com

➤ Social Work and Disability

• SUPPORTING CHILDREN WITH DISABILITY/ A PARENT AND FAMILY INFORMATION KIT
Inclusion International Asia pacific region

• L’ÉVALUATION DE LÀ PARTICIPATION SOCIALE ET DE LA SITUATION DE HANDICAP EN
TRAVAIL SOCIAL
WEBER, Philippe ; NOREAU, Luc ; FOUGEYROLLAS, Patrick
Handicap, revue de sciences humaines et sociales
CTNERHI Publications-number 103- July 2004

• INSERTION SOCIALE DES PERSONNES HANDICAPEES : Méthodologies d’évaluation
RAVAUD, Jean-François ; FARDEAU, Michel
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➤ Social Work and Development

• REPORT ON THE WORLD SOCIAL SITUATION
United Nations General Assembly, July 2005

• ASIAN TSUNAMI AND SOCIAL WORK PRACTICE – Recovery and rebuilding
TIONG, ROWLANDS and YUEN
The Haworth Press, Inc.- 2006

• SOCIAL WORK IN THE CONTEXT OF POLITICAL CONFLICT
International association of schools of social work, 2008

➤ Contexts, Methods and Tools

• COMMUNICATING SOCIAL SUPPORT: ADVANCES IN PERSONAL RELATIONSHIPS
GOLDSMITH, Daena J.
Cambridge University Press - 2004

• SOCIAL SUPPORT: THEORY, RESEARCH AND INTERVENTION
VAUX, Alan
Praeger publishers - 1988
• SOCIAL WORKER’S DESK REFERENCE
ROBERTS, Albert R.
Oxford University Press - 2009

• ACTION SOCIALE ET LUTTE POPULAIRE
GROULX Lionel
Canadian journal of Sociology – Vol. 6 – 1981

• ELABORER SON PROJET D’ETABLISSEMENT SOCIAL ET MEDICO-SOCIAL:
contexte, méthodes, outils
LOUBAT, Jean-René
Ed. Dunod - September 2000

• LA PRATIQUE DU TRAVAIL SOCIAL AVEC LES GROUPELES
MASSA, Hélène
Edition ASH, collection ASH-professionnels

• LA SUPERVISION D’EQUIPES EN TRAVAIL SOCIAL
ROUZEL, Joseph
DUNOD, collection Action Sociale, 2007

►International Social Work

• INTERNATIONAL SOCIAL WORK - SOCIAL PROBLEMS, CULTURAL ISSUES AND SOCIAL WORK EDUCATION
BORMANN, STEPHAN, KLASSEN and SPATSHECK
Barbara Budrich publishers - April 2007

• JOURNAL OF INTERNATIONAL SOCIAL WORK

• GLOBAL SOCIAL WORK CONGRESS REPORT
Adelaide Convention Centre (Australia) October 2004

• INTERNATIONAL NORMS FOR QUALITY EDUCATION AND TRAINING IN SOCIAL WORK
International association of schools of social work

►Social Work and Ethic

• ETHICS IN SOCIAL WORK, STATEMENT OF PRINCIPLES
International Social Work federation, 2004

►Hi Internal Publications

• INTEGRATION : FIRST STEPS TOWARDS AN INDEPENDENT LIFE
SOKOLOVA, Marina ; CABOURG, Laurent
Handicap International Moscow, 2004
• BEYOND DE-INSTITUTIONALISATION : THE UNSTEADY TRANSITION TOWARDS AN ENABLING SYSTEM IN SOUTH EAST EUROPE
ADAMS Lisa, GRANIER Pascal, AXELSSON Charlotte, 2004
http://www.disabilitymonitor-see.org/indexe.htm

• CAPACITY DEVELOPMENT AND PARTNERSHIP : OVERVIEW AND METHODOLOGY
Stephanie Ziegler, TA « Partnership », methodology unit

• GUIDE PRATIQUE POUR L'AIDE A LA MISE EN PLACE D'UN CENTRE LOCAL D'INFORMATION ET D'ORIENTATION (CLIO) : MODELISATION D'UNE EXPERIENCE DE CLIO A SALE (MAROC)
Eric Plantier-Royon, RT « Ville et Handicap », domaine Insertion, 2007

• CAHIERS THEMATIQUES
N°1 : Le plan d'intervention individualisé interdisciplinaire (March 2005)
N°2 : Le projet de vivre chez soi d'une personne en situation de handicap au Maghreb (October 2005)
N°3 : Les groupes de parole (September 2006)
N°4 : La fonction de cadre de proximité en réadaptation au Maghreb (November 2006)
N°5 : Le projet d'établissement des structures à caractère médicalisé, éducatif et/ou social de la région Maghreb (March 2007)
N°6 : Une nouvelle offre de service au Maroc : l'unité de réadaptation du Centre Noor de Bouskoura (July 2007)
N°7 : Dix ans d'expérience des dispositifs mobiles de dépistage et de réadaptation en Tunisie (July 2007)
N°8 : Rendre possible la participation sociale des personnes en situation de handicap en Algérie : les espaces de socialisation (EDS) (July 2008)
http://www.handicapinternational-maroc.org/puplication.htm

► Web Sites

IFSW – International Federation of Social Workers
www.ifsw.org/

CASW – Canadian Association of Social Workers
www.casw-acts.ca/

Inclusion International
http://www.inclusion-international.org/

European Journal of Social Work
http://www3.oup.co.uk/eurswk/

IASSW - International Association of Schools of Social Work
http://www.iassw.aiets.org/

CIDA – Canadian International Development Agency