DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'DEPARTMENT CENTRES FOR DISABLED PEOPLE - MDHP' –	
2. Organisation responsible for the practice	
National Solidarity Fund for Autonomy – CNSA *Caisse nationale de solidarité pour l'autonomie*	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. National/regional/local context of the practice	

The creation of the MDPH is a central component of the renewed disability law passed in 2005. This law sets a new regulatory framework for disability policies.

Law number 2005-102 (11/02/2005) for the "equality of rights and equal opportunities, participation, and citizenship of people with disabilities" (articles .146-9) creates the MDPH through the merger of other previously relevant entities (Cotorep, CDES and SVA), and a renewed approach to both the technical organisation of the service and of its governance. Three newly created key mechanisms by the law need to be highlighted:

- Creation of "multidisciplinary teams": merging of the teams from different institutions (Ministries of Labour, Education and Social Affairs, General Council) under the authority of the newly created "Groupement d'interet public" (GIP) entity. This joint team assesses persons' needs and suggests solutions to the Commission CDAPH.
- Creation of the "Commission for the Rights for independent living for People with Disabilities" (CDAPH): a decision-making body that grants different rights to people with disabilities based on the suggestions of the multidisciplinary teams. The commission's members are the public institutions, as noted above, the Regional Health Agency (created in 2009 to get health and medico-social sectors closer), and user organisations. The decision criteria fit the perimeter of competencies of the public authorities initially present in this body, i.e., labour,

social affairs, education, and care. Health services are for instance out of the scope in spite of the creation of the Regional Health Agencies.

- Creation of the Executive Commission, with roughly the same representatives as in the CDAPH. This is the governing body of the MDPH. Its president is always the president of the County Council.

This integrated governance approach allows for the integration across stakeholder organisations: a very innovative approach to joining the forces of state services/local authorities/user organisations.

5. Summary of the practice

The MDPH are a new public service created by the 2005 Disability Act and the central government merger of three separate government agencies concerned with disability support services, benefits and independent living and their staff. There are 101 such decentralised, jointly-governed 'departmental centres for people with disabilities' (MDPH) in France (1 per county/département). The MDPH works as a one-stop shop for all requests concerning individual disability aspects. MDPH centres assess needs and eligibility for minimum income support; personal assistance payments; housing adaptation and technical aids; specialised care; employment, and education. Despite an improved integrated approach, examples have shown that needs assessments can still be segmented and dominated by a medical approach. The health sector needs to be fully engaged in that process.

6. Staff involved

When the MDPH was created, professionals from different services of the state and local authorities were transferred to these departments.

Integrated teams deliver multi-disciplinary needs assessments for all disabled people and people with mental health problems or acquired brain injury (apart from people over the age of 60 with age-related disabilities).

The Centres have the necessary multi-disciplinary capacities to address complex needs as well as to respond to simple procedural requests. If necessary, the core multidisciplinary team can involve services and specialist advisors in the assessment process. One of the main tools is the multi-dimensional evaluation guide (GEVA), which is meant to serve as a single tool for all existing assessment forms and evaluations. Some information-sharing tools (a "picture" of the person's situation, sheets for homogeneous transmission of information on the situation by different partners) have been developed locally along this guide.

The centres also address transitions and service continuity for disabled people aged 16 to 25 years.

MDPH staff from different backgrounds have shared training and networking meetings for an improved shared working culture. There are still issues in establishing common values and approaches between health and social services staff.

7. Target group

All people with disabilities (except for age-related disabilities occurring after the age of 60) and people considering they have a disability. This includes varied types of disabilities: physical, mental, learning, developmental, speech/language, brain trauma, and psychiatric (this last category was only recognised as a disability within the 2005 law). This concerns both people with mild and severe disabilities. More and more, the MDPH supports young people aged 16-25.

8. Aims of the practice

- Ensuring a coherent, integrated approach to the assessment and provision of services, benefits, employment, and support to disabled people.
- Collaborative delivery of a national programme to improve the coherence of needs and eligibility assessment of all disabled people and people with mental health problems.

9. Issues for social services

Service Integration/ Cooperation across services	X	Service Planning		Contracting	
Technology		Skills Development (of the workforce)		Quality of services	

Other: *multidimensional needs assessment for people with disabilities*

ANALYSIS OF THE PRACTICE

10. Status

Pilot project (ongoing)	
Pilot project (terminated)	
Project (ongoing)	
Project (terminated)	
Implemented practice (restricted areas)	
Widely spread practice/rolled out	X

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro-level practice: a* practice that involves individuals at the local level
- *Meso-level practice: a* practice that involves organisations or communities
- *Macro level practice: a* practice that involves large population groups

There are roughly three ways in which the cooperation takes place (beyond the core multidisciplinary team of the MDPH):

- particular services (education, employment, care) take part in the enlarged multidisciplinary team when the individual life situation of a user requires a more targeted approach. The involved services directly contribute to the creation of the action plan for the user.
- other involved services (education, employment, care, but also health and social services) contribute to the assessment done by the MDPH team through the transmission of relevant information about the user's situation (with the agreement of the user)
- some specialized services provide assessment services complementary to those of the MDPH team. Most often in the fields when MDPH does not have the expertise internally (e.g., housing, assistive devices, specific disability types such as autism, psychiatric disability, etc.)

12. Leadership and management of the practice

Describe the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional, and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Every MDPH is a "public interest grouping" ("Groupement d'interet public" or GIP), a legal statute that allows for joint governance by several public and private stakeholders:

- state services at the department level: labour, social affairs, education, and care;
- local government ("General council" up until March 2015, now Departmental/county council)
- user organisations (who also run services for people with disabilities)

MDPH is competent in assessing the needs and granting access rights in the fields of a minimum income for people with disabilities, personal assistance compensation, housing adaptation, technical assistance, specialised care facilities, employment, and education.

CNSA (National Fund for Solidarity and autonomy, a national body responsible for MDPH and ESN members) provides teams with official guidelines for the situation assessment. They still need to cover the entire scope of the MDPH work, but it is a work in progress. These guidelines are usually created in collaboration with team members during network meetings or ad-hoc working groups.

13. Engaging stakeholders in the practice

Describe the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

See also sections 6. and 4.
The MDPH has been created at the national level. When the MDPH was created, three services were merged, and professionals from different services of the state and local authorities were transferred to the MDPH, thus creating new integrated teams in each MDPH. The centres have multi-disciplinary teams comprised of staff from agencies and departments that merged to become MDPH centres. These include medical, social, occupational and educational practitioners. A medical practitioner generally leads the teams.

The GIP (see section 12) mandatory members in each department are:

1. decentralized state services in the fields of employment, education, social protection, and health
2. county Council = locally elected authority, which shares the responsibility with the state services in the field of social protection
3. user organisations representing People with Disabilities.

The members of the GIP are represented in both the executive commission (a governance instance) and the Decision-making commission (that decides whether to grant access to different rights based on the advice of the MDPH team).

The MDPH gathers different kinds of professionals that are either hired or provided by GIP members: doctors, occupational therapists, social workers, teachers, employment specialists, and administrative staff.

14. Involvement of service users and their families

Describe the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for an ongoing dialogue and feedback* *Involvement in care: person-centred approaches to care/support*

The users are invited to express “a life project”, which should describe their wishes and aspirations for the MDPH. Some MDPHs put in place **specific mechanisms to help users fill out this form** (interviews with trained professionals). Users are supposed to receive a compensation plan before it is transferred to the decision-making commission so that they can express their disagreement with the MDPH’s suggestions (in progress). Users organisations are part of the GIP (“public interest grouping” (“Groupement d’interêt public”), a legal statute that allows for joint governance by several public and private stakeholders.

15. Costs and resources needed for implementation

Describe how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided ‘in-house’
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services *Funded project:* external investment

Integrated funding comes through each MDPH “Public Interest Grouping” from state services at the departmental level and local government.

16. Evaluation approaches

Describe the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and a quantitative approach
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and/or other routinely collected service data.
- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*
- *An evaluation is planned*

An evaluation has been carried out in the form of staff interviews, surveys, and data analysis. Staff and directors have been surveyed, but service users and carer experiences still need to be captured. Studies have focused on assessment practices, the use of nationwide tools and overall effectiveness and efficiency.

17. Measurable effects of the practice and what it has achieved

Service users	
Formal caregivers	
Informal carers	
Organisations	

18. Anticipated or 'aspirational' effects of the practice and what it has achieved

This category can include outcomes which are not documented, quantified, or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.

Service users	The main impact is on young people becoming adults. Even though it is not yet generalised, more and more MDPHs put in place specific assessment teams for the age group of 16 to 25 years, which allows for taking care of this transition period and having a coherent approach in terms of training/professional life/specialised housing, etc. Before, two distinct services were responsible for children with disability and adults with disability. This does not solve all the issues since the care institutions are organised by age group and most young people do have to change the service when they become adults. Yet, this joint strategy allows for a more gradual approach to the evolution of the situation of the young person. For service providers and user organisations, the MDPH teams have simplified the interaction with various agencies as they now have only one point of contact.
Formal care givers	
Informal carers	

Organisations	A shared professional culture was built between external professionals originally coming from different public service organisations (see point 4). An integrated approach between different types of expertise was implemented. There are, however, limitations to this integration, as, in fact, often only one professional is responsible for assessing the situation. Usually, a doctor and each member of a team should be able to perform multi-dimensional assessments. For service providers and user organisations, the MDPH teams have simplified the interaction with various agencies as they now have only one point of contact.

19. How has the practice changed the way the service is provided

MDPH teams allow for a more integrated, individualised approach to the needs assessment of disabled people.

20. Sustainability of the practice

Describe if the practice is sustainable, considering the following criteria:

- *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)?
- *Organic sustainability:* service users have been empowered to take the practice forward
  Established: the project has been operational for several years

The initiative has been implemented nationally in all 101 counties (départements).

21. Transferability of the practice

Describe if the practice has been transferred, considering the following criteria:

- *Transferred:* transfer to other regions, countries, service user groups, etc.
- *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed

Integrated needs assessments could be implemented for other user groups.

22. Further information sources/background documents / Website

ANED Country report on the implementation of policies supporting independent living for disabled people (France) – here