

2010



# WP2 Synthesis Report

## FRANCE

**Deliverable N° 24**

Project:  
Development of a Common Training  
Programme for ABI Caregivers (ABI)

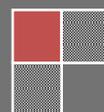
Project Number: 505666 – LPP-2009 –SI- LEONARDO-LMP

Grant Agreement: 2009-2203/001-001



This project has been funded with support from the European Commission. This report reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

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### PS:

**Introduction:** This section introduces the main sections of the report as well as the primary people involved in conducting the analysis and producing the report. The target audience is also clearly identified. This section provides any information that might be needed by the reader to understand the background to the analysis, e.g. who initiated it and why. It should include the results of any previous training needs analyses, and a summary of training experience to date.

**Aims and objectives:** This section describes the purpose(s) of the analysis.

**Methodology:** This section describes the analysis techniques used, such as observations and surveys. It should provide step-by-step descriptions of the work carried out.

**Target audience:** This section describes the staff, trainers and other personnel involved in the analysis.

**Results:** This section presents the findings of the analysis. Graphs, charts and diagrams should be used wherever appropriate.

**Recommendations:** This section puts forward recommendations, based upon the findings reported in the previous section.

**References:** This last section lists the sources reviewed or consulted during the analysis.

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## PREAMBLE

Acquired brain injuries (ABI) are an epidemic of modern times and one of the biggest medico-social problems in the western world. High quality care is usually available in the fields of acute medicine and surgery. However, difficulties arise in the later stages when, all too often, little is done to relieve the long-term, often permanent problems faced by victims and their families after an ABI. The consequences of ABI are often extensive and wide ranging, and can cause distress and concern for people working directly with ABI patients, especially newly-recruited, inexperienced staff and staff in pre-existing community service models (caring for people with developmental disabilities and mental illness, in nursing homes, etc.). Long-term care raises different questions and problems to acute care. The growing number of people with ABI in the community, the increased interest in ABI, the growing number of people working in the field, and the belief that ABI raises problems that are neither clearly understood nor properly dealt with, have created a genuine need for a specialized, formally-defined “how-to-do-it” guide. In 2008, a survey was conducted among staff working directly with ABI patients in various institutions and organizations in Slovenia. According to this survey, 95% of staff needed specialized training, and 80% agreed that the training curriculum should include specific topics like the cognitive, psychological and social consequences of ABI, and behavioural approaches to managing challenging behaviours and promoting positive skills.

### 1. EXECUTIVE SUMMARY

This synthesis report outlines the process undertaken by the Consortium of the “ABI” project (***“Development of a common training programme for ABI caregivers”***), which began in October 2009 and is scheduled to last for 25 months.

The aim of the ABI project is to define a common training programme for long-term ABI caregivers/providers (based on the knowledge and experience of different countries), and hence to develop a formal, pan-European approach to staff training in this field. The ABI project will ensure that staff develop the knowledge, skills and attitudes needed to deliver quality services. It will also provide for the recognition of skills and potential, and enhance the appeal of working in long-term care and support services for ABI patients.

The ABI project partnership includes the following 8 partners:

- Zavod Zarja / Slovenia (applicant organisation, coordinator)
- Zavod Korak / Slovenia
- Zavod Naprej / Slovenia
- VDC Nova Gorica / Slovenia
- Regionalis Szolialis Forraskozpont Kht. / Hungary
- Mutualite Francaise Anjou-Moyenne-Arceau-Anjou / France
- Berufsforderungsinstitut Oberosterreich / Austria
- European Association of Service Providers for Persons with Disabilities (EASPD) / Belgium

As part of the ABI project, these partners have conducted a Training Needs Analysis (TNA). This synthesis report summarises the training needs survey conducted in France in December 2009.

## 2. INTRODUCTION

This analysis of the specific long-term supportive care needs of brain-injured people, conducted as part of the ABI project, is the first of its kind in France. Long-term supportive care is a recent trend in France, which has, over the last twenty years, grown from local initiatives into various healthcare policies. The founding text in this field was the so-called “Bauduret” circular, issued in 1996. This text provides a basic framework for the organisation of facilities and professionals in this field (excluding medical care and hospital services). In view of the wide range of specific disabilities and needs to be addressed, the professionalisation and training of staff working directly with ABI patients poses something of a challenge in terms of providing high-quality care. Despite this, attempts to match training programmes to needs have not been clearly assessed. This analysis provides an opportunity to determine the role of professional training in the development of service quality.

This report presents the results of 3 initiatives carried out between November 2009 and January 2010:

1. A questionnaire survey of 55 professionals working in the field of Acquired Brain Injury (ABI). The statistically processed results are analysed in this report, and provided in full in the appendixes.
2. An interview of 17 people disabled by ABI, on what they expect from professionals in terms of knowledge, skills and behaviour.
3. The collection of data on existing, specialised training programmes in France. This data is provided in full in the appendixes to this report. **Regarding this particular point, we felt it was important to point out the following factors, which are specific to France:**

*We identified several programmes in France, delivered by continuing vocational training organisations and by universities. We decided to focus our study on two types of training programme, which seemed sufficiently widespread to constitute an observation and analysis model for our project.*

- *Training programmes leading to a university degree*
- *Continuing vocational training programmes involving at least 30 hours or 5 days of training*

*These programmes – which are described after this introduction – were subjected to critical analysis at the national conference of 08 February 2010.*

*The aim of this conference, which was attended by various people involved with Acquired Brain Injury, was to identify the qualitative and quantitative indicators needed to develop an “ABI” training programme.*

*Nevertheless, it is important to point out that, in France, other people and activities also contribute to promoting awareness of ABI and developing specific measures and training programmes relating to the long-term supportive care of ABI patients.*

These include:

1. Organisers of forums and thematic days, such as UNAFTC (national union of associations representing people with traumatic brain injuries and their families), France Traumatisme Crânien, SOFMER (French Society of Physical and Rehabilitation Medicine), Les entretiens d'AIX, etc.
2. Resource and reference centres on Acquired Brain Injury, such as the CRLC (brain injury resource centre) of Grenoble, the CRFTC (traumatic brain injury resource centre) of Paris, the "Centre de Suivi et d'Insertion pour l'enfant et l'adolescent après atteinte cérébrale acquise" (unit for the Follow-up and Insertion of Children and Adolescents with Acquired Brain Injury) at St Maurice National Hospital, etc.
3. Medico-social institutions, such as Arceau Anjou and ARTA (Association for the Rehabilitation of Brain-Injured People) in the North-West of France, which organise awareness campaigns and short training programmes (1 or 2 days), and provide support for other organisations struggling to fulfil their missions
4. Local (often regional) networks, which act in various ways to maintain the quality of user services (notably by improving the understanding and management of ABI and of related conditions)

Although these activities are not the main focus of our study, they are important because they seem to respond to the specific needs identified by professionals providing medico-social care, i.e.:

- The analysis of practices
- The management and mediation of difficulties encountered
- The exchange of information
- Technical support and advice on how to act
- The updating of legislation
- Etc.

The study does not include an analysis of existing modules within basic training programmes in the medical, paramedical and community education fields. Such training programmes are delivered by government-approved schools (nursing colleges, schools for occupational therapists and for special education teachers, etc.). They are therefore regulated and "calibrated" to meet legal standards, and it is difficult to conduct a critical analysis of them.

Nevertheless, we can make two observations at this stage:

- In France, these basic training programmes are still split into two – basically non-communicating – areas of expertise (medical/paramedical and socio-educational). However, these two areas are intrinsically linked when it comes to the care and rehabilitation of brain-injured patients. Employers have pointed out that this division is a major impediment to the development of multidisciplinary action plans, and therefore to the provision of high-quality services. One of the challenges involved in developing a specific continuing education programme is thus to bridge the gap between these two areas of expertise.
- The second observation is that there is a clear lack of specific brain injury training in these schools. Course content is still very general, and is included under the blanket heading of "neurology". This does not inspire future healthcare professionals to take into account the specific needs of our end-users/patients. Moreover, the practical aspects are largely ignored.

*Seen from this angle, continuing vocational training could be a necessary complement to the basic training of young professionals just entering the workforce.*

In order to identify specific needs and existing training programmes, we put together representative samples of the different branches of the field, rather than a broad panel of representatives that would have taken too much time to process. Hence, this study involved several regions of France, all the occupations representative of and involved in the hospital and medico-social sectors, and “peripheral” players such as training organisations, human services providers, etc.

This work was finalised at a national conference on 8 February 2010.

### **3. AIMS AND OBJECTIVES**

This analysis has several aims and objectives.

Those inherent to the “ABI” project itself:

- 1. Collect data to establish an overview of the training needs of the service providers / caregivers working with people with acquired brain injury (and review and analyse key needs)*
- 2. Identify existing relevant training programmes and guidelines in Europe (and review, analyse and identify examples of good practices, based on developed criteria)*
- 3. Invite additional and relevant national stakeholders to participate, and to jointly define practical strategies and ideas for developing a rough version of a common transnational training programme for service providers/caregivers*
- 4. Start to develop a draft of a common transnational training programme*
- 5. Ensure that the training content covers topics that address participants' needs and gaps in knowledge*

Those defined according to specific national and local needs:

- 1. Adapt common tools and methods to local requirements = we have revised the method of collecting data on vocational training needs, and developed a data processing tool on the basis of the most meaningful indicators for us*
- 2. Identify a representative sample of the ABI care and services field in France, based on a number of criteria: per region, per type of structure, per age of structure, etc.*
- 3. Create additional tools, such as the grid for evaluating existing training programmes (see appendixes)*
- 4. Pinpoint (as accurately as possible) the actual needs of users and professionals, and identify existing training solutions and shortfalls on a national level*
- 5. Widely publicise the Community project through the media and bring on board partners who – thanks to their specific expertise – are able to make a relevant contribution*

## 4. METHODOLOGY

The methodology to be used was defined during the project design and engineering phase; at the same time our leader suggested using certain tools. However, we had to adapt some of these tools to match specific national characteristics (differences in job descriptions, different conceptual data models, etc.) and to take account of specific difficulties, such as the poor ability of some users to discuss this issue.

### **4.1 Identification of training needs among professionals**

**Chosen tool:** The questionnaire developed by Zarja (appendix 1), which we altered slightly to take into account the lifestyle habits and culture of our users. This questionnaire was distributed to some organisations. The questions were compiled according to the goals of the project and were common to all participating countries. They cover two main areas: individual training needs and self-assessment. Personal characteristics (education level, gender, age, profession) were also asked for. We distributed this questionnaire between weeks 48 and 51.

**Target audience:** We distributed the questionnaire via our national network, targeting a sample population that seemed to be representative of all the professionals in our sector. We defined our target sample in such a way that it reflected the characteristics of all the professionals working with brain-injured people. We paid particular attention to the characteristics that could influence respondents' answers. We therefore made sure that we covered the full range of occupations, workplaces and regions. It should be noted that the healthcare and medico-social professions in France are dominated by women, who therefore represent a large sample in this study.

The questionnaire was distributed mainly to paramedical workers. However, we also made sure that it was distributed to special education teachers, medical psychology assistants, trainers, doctors, social workers, secretaries, etc.

The organisations in which these professionals work are also relatively representative of existing services in France: hospitals, functional rehabilitation centres, in-home medical and social services, assessment and rehabilitation services, halfway residences, etc.

The questionnaire was sent out to locations throughout France.

**Data collection method:** We chose two collection methods: by post and online. In many cases, we contacted the respondents by telephone before sending out the questionnaire in order to explain the background to our request, and to stress the importance of distributing the questionnaire to professionals in different branches and of meeting the timeline.

**Data processing:** We used a data processing programme that enabled us to access a very broad spectrum of data. Hence, we did not use the recommended Excel file, which did not seem adequate in terms of its data comparison capability.

- ✚ We mainly used the table sort feature. This resulted in the "frequency distribution" table, showing the number or percentage of individuals in each modality. First, we highlighted the most and least important areas of competence for the professionals.
- ✚ We also presented the self-estimated knowledge of the professionals in each area.
- ✚ We then compared this data in order to define possible areas of discussion regarding training programme content.
- ✚ Finally, we identified areas in which the professionals felt they lacked theoretical training, and areas in which they felt they needed more practical training.

Having processed the data from all the questionnaires, **we applied multi-criteria filters to generate sub-populations and to refine our analysis according to “occupational category”**. We applied the above analysis procedure to each of the following categories: administrative, medical, social and educational, and paramedical.

The results – in table and graphic form – were inserted into a PowerPoint file and used at the national conference. They are presented in appendix 3.

#### **4.2 Identification of user expectations regarding**

##### **The skills of professionals**

**Chosen tool:** The users of our services may have comprehension and language difficulties, so the questionnaire did not seem appropriate for them. We therefore opted to use interviews, which can be adjusted as and when required and can be used to investigate certain subjects in depth, while fostering a participatory approach. Our interview sheet contained an open question on the expectations of users regarding the professionals working with them. Then the users were asked to assess the importance of the skills listed in the professionals’ questionnaire, in terms of meeting the needs expressed at the start of the interview.

**Target audience:** The group of interviewees was small (17 people), but nevertheless representative of the users of all our services. We interviewed users of the halfway residence, UEROS (evaluation, retraining and socio-vocational counselling unit), SAMSAH (domiciliary medico-social care service), ESAT (establishment implementing inclusion through employment programmes), CAJ (daytime activities centre) and FAM (healthcare home for disabled adults).

**Data collection method:** We opted for an interview approach so that we could establish a dialogue with the participants and go back over any points that needed clarification. The interviews were semi-guided and conducted individually within each service. All the interviews – which were conducted on a voluntary basis – began with an introduction to the background and objectives of the meeting. They lasted for 20 minutes.

**Data processing:** We organised interviewee responses according to theme, which enabled us to highlight dominant issues and hence to identify user needs. This data was included in the PowerPoint presentation shown at the national conference.

#### **4.3 Identification of existing training programmes in France**

We relied on the Internet and on contacts within our network to identify continuing training programmes focusing specifically on brain injury.

We distinguished courses that lead to a degree or a diploma from those that do not<sup>1</sup>. We then defined a set of quality criteria, which was used as a working framework at the national conference. We selected structural criteria for each category (diploma/non-diploma courses) and developed an evaluation grid that could be used to analyse all the components of the training courses identified<sup>2</sup>.

The criteria defined are based on the criteria specified in the quality procedure, and in the AFNOR and ISO quality standards relative to continuing vocational training.

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<sup>1</sup> Appendix 3

<sup>2</sup> Evaluation grid in appendix 4

## 5. TARGET AUDIENCE

### 5.1 Identification of training needs

The questionnaire on training needs for professionals was e-mailed to individuals and staff in various organizations and institutions across France, mainly with expertise in ABI long-term rehabilitation (for example, a handful of hospitals with special neurological services, specialized nursing homes and other ABI support services). In addition, we sent it to a few associations providing services for disabled people. Most of the questionnaires were sent to service provider managers, who were asked to coordinate the distribution and the return of the questionnaires wherever possible.

We sent out 100 questionnaires and achieved about a 50% response rate. The time factor largely accounts for this low participation rate in France, however other factors probably also play a part:

- ✚ The anteriority of project communication at a national level: the questionnaire was sent out in the early stages of our project communication strategy
- ✚ Competition fears on the part of organisations that specialise in brain injury and also provide continuing training on topics covered by the ABI project
- ✚ The complexity of the questionnaire for many professionals

### Sources of returned questionnaires

#### **Per region: France: 34**

1. Arceau Anjou influence area (western France): 18
2. Paris area: 4
3. North – North/East: 6
4. South - South/West:6

#### **Per region: Belgium: 23**

*For several reasons (i.e. level of expertise in providing supportive care for the target population, innovative practices, links with the European Brain Injury Society (EBIS)), we decided to extend our study and to invite our colleagues from “La Braise” in Brussels to participate. Finally, during the ABI project engineering phase, “La Braise” agreed to act as a “silent partner” in the project, which it was interested in but was unable to participate in on an equal basis with the French.*

#### **Per organisation type:**

1. Hospital services (neurology, physical medicine and rehabilitation): 12
2. Medico-social services and organisations, specialising in Acquired Brain Injury: 41
3. Organisations providing services for disabled people: 2
4. Leisure organisations: 1
5. Driving schools: 1

#### **Per respondent:**

##### **Gender:**

- ✚ Female: 82%
- ✚ Male: 18%

**Average age:** 36.5 years

**Occupational category:**

- ✚ Paramedical: 52%
- ✚ Educational and social: 38%
- ✚ Medical: 6%
- ✚ Administrative: 4%

## **5.2 National conference**

The purpose of the national conference was to:

1. Present the results of the needs analysis, and invite selected partners to take part in reviewing these results in relation to the objectives of the ABI project: type of professionals concerned, training needs expressed, etc.
2. Present an inventory of existing continuing training programmes on the supportive care of people with Acquired Brain Injury
3. Analyse these existing programmes in order to identify best practices

The conference was attended by a group of 14 people, which can be broken down as follows:

**Per occupation:**

- ✚ Unit or institution managers: 4
- ✚ Training or HR managers: 2
- ✚ Neurologists: 1
- ✚ Psychologists, neuropsychologists: 2
- ✚ Social workers, special education teachers: 3
- ✚ Occupational therapists: 1
- ✚ Psychomotor therapists: 1

***NB: 5 of the 14 participants also occupy continuing education teaching positions (at universities and specialised paramedical schools)***

**Per organisation or service type:**

- ✚ Hospital neurology services: 1
- ✚ Functional rehabilitation centres: 1
- ✚ Home help services: 1
- ✚ Medico-social organisations for disabled adults: 9

## 6. FINDINGS/RESULTS

### 6.1 Training needs

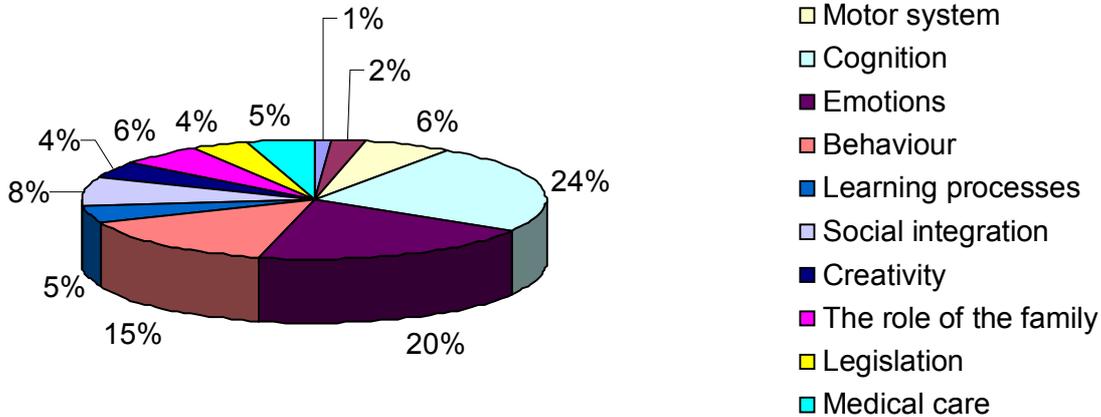
NB: The results are provided in full in appendix 2.

We based our analysis on the 55 completed questionnaires received. Some of the professionals who did not return the questionnaire explained that they lacked the knowledge and, above all, the time to complete it. Moreover, we know that some of our partners did not have enough time to distribute the questionnaire widely.

#### 6.1.1 Responses from professionals:

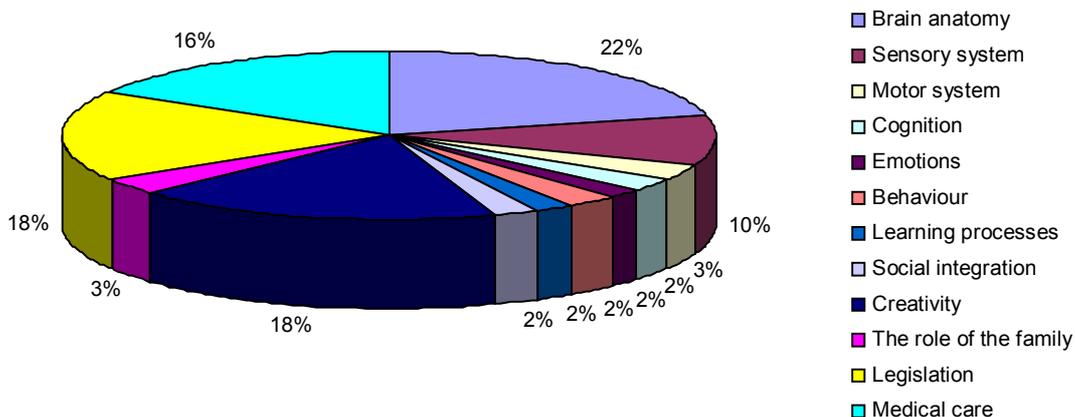
The most important areas of knowledge were identified as **cognition, the emotions and behaviour**. If we look at all the completed questionnaires, we can see that 59% of the respondents placed one of these areas of knowledge in the top three.

#### Areas of knowledge most often quoted as being the most important



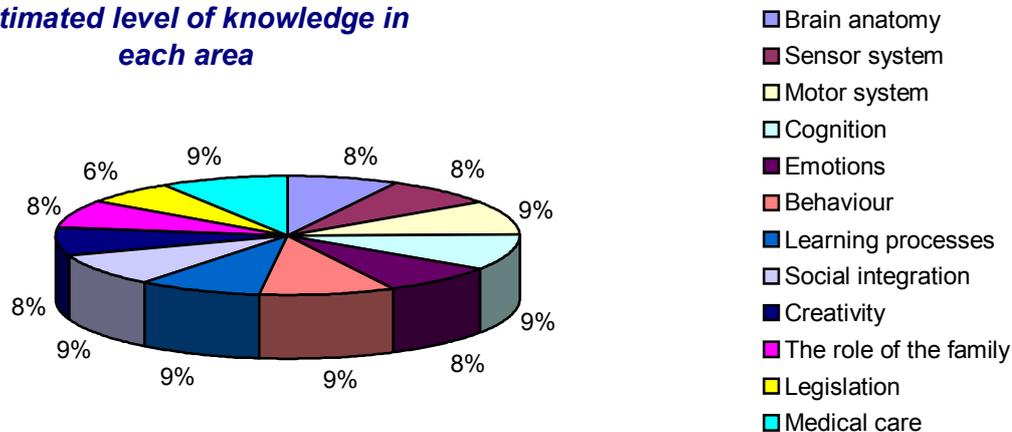
*If we break down our analysis by group of professionals*, we can see that professionals in the administrative, medical and paramedical sectors all said that cognition, the emotions and behaviour were the most important areas of knowledge. However, professionals working in the social and educational sector also mentioned social integration.

The areas of knowledge most often quoted as being the **least important** are brain anatomy, creativity and legislation (for all groups of professionals).



According to the results, the professionals believe that they have a very similar level of knowledge in all areas besides legislation, of which they claim to have the least knowledge.

**Estimated level of knowledge in each area**



However, we have noticed that doctors claim to have a good level of general knowledge (which they mainly graded 4 or 5), whereas other professionals rarely grade themselves so highly in this area.

**If we compare** the data on the importance of knowledge areas with that on knowledge levels, we can see that there is always a correlation between the two. **In fact, the respondents estimated that they have the best level of knowledge in the areas that they believe to be the most important.**

*Does this mean that they feel they do not need further training in these important areas?*

*Or, on the contrary, does it mean that they would like further training in these areas, because the others are less important?*

**With regard to the training content suggested in the questionnaire, the professionals were interested in:**

- ✚ **Theoretical training as far as legislation, the emotions and brain anatomy are concerned**
- ✚ **Practical training on creativity and learning processes**

**Again, we have a theory on this: ➡ legislation, the emotions and brain anatomy are mainly addressed at a theoretical level in France, and it was perhaps difficult for the respondents to imagine using any other learning approach.**

Training content	More practical work	50%	More theory
Brain anatomy	29	28	44
Sensor system	30	39	32
Motor system	33	44	24
Cognition	40	29	32
Emotions	28	34	38
Behaviour	36	37	28
Learning processes	44	33	23
Social integration	30	45	26
Creativity	56	29	17
Role of the family	36	33	32
Legislation	8	25	68
Medical care	20	44	36

### 6.1.2 User responses:

First of all, we asked the users which professionals they were seeing. Generally speaking, they understand what these professionals are there to do.

In answer to the question "*Can you tell us what you expect of the professionals you are seeing?*" **most of the users talked about life skills and behaviour. They expect professionals to be available, attentive and understanding.**

The following answers (to less open questions) indicate that users expect two main things from professionals:

- assistance in their daily living activities, given their various disabilities and difficulties
- availability, appropriate behaviour, a respectful attitude and, above all, consideration of their opinions

In general, users define the roles and obligations of professionals according to their job, and do not have the same expectations of all of them. Consequently, the level of knowledge expected from these professionals differs. The answers given by the users seem to be influenced by the services and organisations working with them, and by the knowledge they have of these services and organisations (which provides a point of reference for them).

## **6.2 Identification and assessment of existing training programmes:**

First of all, we noticed that it is difficult to get hold of information on continuing education programmes for ABI caregivers. The range of programmes available is relatively obscure and diverse, and should be more readily accessible (via a “resource centre” for example).

We identified **21 programmes**, which are presented in full in appendix 4:

- ✚ 5 degree courses (3 inter-university degrees, 2 university degrees)
- ✚ 16 non-diploma courses relating exclusively to brain injury; these courses are provided by organisations working with disabled people (ADAPT, APF, ADAMS, ANFE)

*Short training programmes are continually changing, both in terms of structure, content and methods. So, for two reasons, we focused exclusively on programmes lasting for at least 5 days: firstly, so that we could establish comparison indicators, and secondly because shorter programmes did not seem to be significant, despite the importance attributed to them in our introduction. **Moreover, there is nothing in between these 5-day programmes and university degrees (in terms of continuing education). This deficit is clearly a target for the ABI project.***

Therefore, the purpose of the assessment conducted at the national conference was to analyse these programmes on the basis of pre-defined criteria (see appendix 5) and, by comparing them with the needs expressed by long-term caregivers, to define best training practices for the “ABI” project.

5 participants in the conference hold university or continuing education teaching positions in addition to their main occupation. They were therefore doubly qualified to identify best practices.

**Results of the training programme assessment conducted at the national conference  
(tables to follow)**

<b>Degree courses: 5 programmes assessed</b>	
<p><b>Target audience:</b></p> <p><b>Selected indicators: prerequisites, heterogeneity or homogeneity<sup>3</sup> of the groups</b></p>	<p>Admission is based on the applicant's letter of application and CV, which should show previous qualifications. There are no prerequisites. However, the course is specialised and aimed essentially at high-level applicants. Therefore, it excludes members of the so-called "intermediary" professions, although many of them are in direct contact with users. It targets professionals responsible for devising care strategies, or people wishing to pursue a specialisation (lawyers, doctors, etc.).</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Ensure occupational diversity within groups to promote a multidisciplinary approach / define minimum but not exclusive basic training requirements or adapt programmes to the level of the applicants / participants must be in work.</p>
<p><b>Objectives of the course and expected level of achievement:</b></p> <p><b>Selected indicators: explicit, focused on user needs</b></p>	<p>The objective is to achieve a given level of general knowledge. The skills and behaviours targeted by the course are not specified. In this respect, it complies with the approach generally adopted by universities.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Aim to develop explicit professional skills, based on user needs. Draw up a general reference framework consisting of a common core of skills, followed by more specialised options.</p>
<p><b>Training content:</b></p> <p><b>Selected indicators: specialisation/generalisation, equal weighting of modules, updating of programmes, etc.</b></p>	<p>University degrees focus primarily on organic and pathological aspects and do not contain any practical work. They are however scientifically up-to-date. According to long-term caregivers, modules on the "acute phase" and on "long-term care" are not always equally weighted, and the link between the "knowledge acquired and professional behaviour" is not always established.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Establish targeted levels of knowledge according to the needs of the sector, and define course content according to referenced professional behaviour. Give equal weight to different types of disability: functional, cognitive, behavioural, psycho-affective, environmental, etc. Organise content on the basis of professional activities: assessment, work adjustment training/rehabilitation, integration, special care, psychosocial assistance, etc. When defining content, bear in mind the different approaches and reference models that may be used in other countries and continents. Systemise the role of the International Classification of Functioning, Disability and Health (ICF) and the Disability Creation Process (DCP).</p>

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<sup>3</sup> Heterogeneity was selected as a qualitative criterion, as it is representative of the multidisciplinary approach needed in the care of users.

**Degree courses: 5 programmes assessed**

<p><b>General approach:</b></p> <p><b>Selected indicators:</b> alternance between theory/practical work, duration, volume, methods, course materials, validation</p>	<p>University courses cater to the needs of working people (in terms of alternance) and are ratified by a university degree. However, they focus on academic knowledge to the detriment of practical skills.</p> <p align="center"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Organise content into thematic modules / Alternance training and work / Ensure that the course is long enough to impact on professional behaviour (through the gradual putting into practice of new knowledge). Introduce a course completion certificate. Conduct regular practical work, structure the course around case analyses and studies, and use a wide range of teaching materials.</p>
<p><b>Teaching staff:</b></p> <p><b>Selected indicators:</b> representation of the sector, professional references, coordination</p>	<p>The teaching staff comprises medical school professors of national reputation and high-level professionals, in accordance with university policy. Problems occasionally arise regarding the coordination of interuniversity degrees.</p> <p align="center"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Recruit teaching staff from different backgrounds: experienced professionals, employer representatives qualified in the field of brain injury, and university academics.</p> <p>Appoint a programme coordinator to ensure quality.</p>
<p><b>Information on the course:</b></p> <p><b>Selected indicators:</b> accessibility, appeal, up-to-dateness, etc.</p>	<p>It is difficult for professionals who are not involved in specific networks to get hold of information.</p> <p>Courses are in high demand, as they are scarce, specialised and taught by highly reputable teachers.</p> <p>The programmes are not updated (2004 version for example).</p> <p align="center"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Develop literature on the course – endorsed by reputed teaching staff – and distribute it through resource centres.</p>

<b>Degree courses: 5 programmes assessed</b>	
<p><b>Practical aspects:</b></p> <p><b>Indicators selected:</b> places, dates, times</p>	<p>Courses are available in large, easily accessible cities: Paris, Aix-en-Provence, Bordeaux, Angers, etc.</p> <p>Times and dates are organised to fit in with working hours.</p> <hr/> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Make sure that courses are available in all of the major regions of France (North/West – North/East – Paris region – South/East and South/West). Group sessions together over one week, to minimise disruption to work commitments. Select a training site close to a university and a business community (e.g. Angers and Bordeaux).</p>
<p><b>Cost:</b></p> <p><b>Indicators selected:</b> accessibility according to status, compatibility with the resources developed, clarity of the offer</p>	<p>The courses themselves cost very little, but as they are only available in certain parts of France, participants often have to pay additional transport and accommodation costs.</p> <hr/> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Keep costs reasonable so as not to discourage enrolments.</p>

Non-diploma courses: 16 programmes assessed	
<p><b>Target audience:</b></p> <p><b>Selected indicators: prerequisites, heterogeneity or homogeneity<sup>4</sup> of the groups</b></p>	<p>The courses mainly target healthcare professionals and caregivers. The target audience is less diverse, but the prerequisites appear to be more uniform.</p>
	<p style="text-align: center;"><b><u>Best practices for the "ABI" project:</u></b></p> <p>Same remarks as above.</p>
<p><b>Course objectives:</b></p> <p><b>Selected indicators: explicit, focused on user needs</b></p>	<p>The courses focus primarily on the difficulties encountered by professionals in the field (behaviour disorders, sexuality, memory loss, cognitive disorders, and autonomy in daily life activities). They aim to improve the quality of service provided.</p>
	<p style="text-align: center;"><b><u>Best practices for the "ABI" project:</u></b></p> <p>Focus on developing training content according to the difficulties encountered in the following specific areas: supportive care, work adjustment training, rehabilitation, integration and medical care. The goal should be a high level of service quality.</p>
<p><b>Expected level of achievement:</b></p> <p><b>Selected indicators: are the skills targeted explicitly specified?</b></p>	<p>The skills targeted are specified, and the aim is to take better account of specific care and treatment requirements.</p>
	<p style="text-align: center;"><b><u>Best practices for the "ABI" project:</u></b></p> <p>Draw up a general competence framework relating to the long-term care of brain-injured people.</p>
<p><b>Training content:</b></p> <p><b>Selected indicators: specialisation/generalisation, equal weighting of modules, updating of programmes, etc.</b></p>	<p>Courses are often specialised and consist of a full module on a single topic (ADPT/ANFE/ADAMS). One organisation (APF) provides a more general awareness course, which covers several topics without going into much depth. Content is updated.</p>
	<p style="text-align: center;"><b><u>Best practices for the "ABI" project:</u></b></p> <p>Develop full modules on the topics and issues encountered by professionals in their day-to-day work, focusing on: the evaluation of abilities and of living habits, the development of "made-to-measure action plans" and the implementation of "personal projects".</p>

<sup>4</sup> Heterogeneity was selected as a qualitative criterion, as it is representative of the multidisciplinary approach needed in the care of users.

<b>Non-diploma courses: 16 programmes assessed</b>	
<p><b>General approach:</b></p> <p><b>Selected indicators:</b> intra/inter, alternance between theory/practical work, duration, volume, methods, course materials, certification</p>	<p>These programmes do not provide for alternance training: it is assumed that participants have adequate work experience. Specific, 5-day modules seem to be sufficient to address a subject in depth, and to implement a wide range of training materials. Active teaching methods are applied, which foster discussion between the participants. No certificate of achievement is delivered at the end of the course.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Allocate 3 to 5 days to each specific module in order to cover topics in depth and implement a wide range of training materials. Implement active teaching methods, which foster discussion between participants. Evaluate the level achieved through a practical assessment of observable skills.</p>
<p><b>Teaching staff:</b></p> <p><b>Selected indicators:</b> representation of the sector, professional references, coordination</p>	<p>A diverse team comprised essentially of seasoned and high-level professionals. The teaching staff almost always includes doctors. Courses are coordinated by specially appointed managers.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Recruit teaching staff from different backgrounds: experienced professionals, employer representatives qualified in the field of brain injury, and university academics. Include doctors to provide a link between hospital care and long-term care.</p>
<p><b>Information on the course:</b></p> <p><b>Selected indicators:</b> accessibility, appeal, up-to-dateness, etc.</p>	<p>It is difficult for professionals who are not involved in specific networks to get hold of information. Courses are in high demand, as they are scarce, specialised and promoted by reputable organisations.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Develop literature on the course – featuring reputed teaching staff – and distribute it through resource centres.</p>
<p><b>Practical aspects:</b></p> <p><b>Indicators selected:</b> places, dates, times</p>	<p>Uneven geographic distribution of courses (characteristic of France). This unequal distribution stems from the fact that the speciality originally developed in the Paris basin and the West of France.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Make sure that courses are available in all of the major regions of France (North/West – North/East – Paris region – South/East and South/West). Group sessions together over one week to minimise disruption to work commitments. Select a training site close to a university and a business community (e.g. Angers and Bordeaux).</p>
<p><b>Cost:</b></p> <p><b>Indicators selected:</b> accessibility according to status, compatibility with the resources developed, clarity of the offer</p>	<p>Unlike university programs, such courses are priced freely. Therefore prices vary widely, which leads to some confusion as to what exactly is on offer. The cost is not always specified.</p> <p style="text-align: center;"><u><b>Best practices for the "ABI" project:</b></u></p> <p>Keep costs reasonable so as not to discourage enrolments.</p>

## 7. RECOMMENDATIONS

### 20 recommendations for developing a high-quality training programme

1. Aim to develop explicit professional skills, based on the needs expressed by professionals and by employers in the sector.
2. Develop a “key competence” framework for those involved in the long-term care of brain-injured people. This should include a common core of knowledge and skills, to ensure that all professionals in the sector adopt the same approach to patient care.
3. The programme should aim explicitly to improve the level of service quality provided.
4. Recruit participants from different backgrounds, with the ultimate aim of promoting a multidisciplinary approach to patient care.
5. Make sure that the participants are working at the time of the course.
6. Group sessions together over one week to minimise disruption to work commitments.
7. Select a training site close to a university or a business community, such as Paris and Bordeaux in France. Make sure that courses are equally available in all the major regions (in France: North/West, North/East, the Paris region, South/East and South/West).
8. Define 2 separate courses of specialisation, according to level: one for medium-qualified professionals (up to advanced [high school] level in France) and one for graduate-level professionals and beyond. Objectives: diversify the offer and reach the least-informed professionals.
9. Develop full, 3 to 5-day modules on the different topics and issues encountered by professionals in their day-to-day work, focusing on: the evaluation of abilities and of living habits, the development of “made-to-measure action plans” and the implementation of “personal projects”.
10. Allocate 3 to 5 days to each specific module in order to cover topics in depth and implement a wide range of training materials.
11. Define training content according to the difficulties encountered in the following specific areas: supportive care, work adjustment training, rehabilitation, integration, psychological support, family mediation and medical care.

12. When defining content, bear in mind the different approaches and reference models that may be used in other countries and continents.
13. Always discuss the role of the International Classification of Functioning, Disability and Health (ICF) and of the Disability Creation Process (DCP), the implementation of which is compulsory in Quebec (Canada).
14. Make sure that the programme allows for alternance training and that it is long enough to impact on professional behaviour through the gradual putting into practice of new knowledge.
15. Include regular practical work, structure the course around case analyses and studies, use a wide range of teaching materials, and promote discussions between professionals and the analysis of practices.
16. Introduce a course completion certificate. Evaluate the level achieved through a practical assessment of observable skills.
17. Recruit teaching staff from different backgrounds: experienced professionals, employer representatives qualified in the field of brain injury, and university academics. Include doctors to provide a link between hospital care and long-term care.
18. Appoint a programme coordinator to ensure quality.
19. Develop literature on the course – endorsed by reputed teaching staff – and distribute it through resource centres.
20. Keep prices reasonable so as not to discourage enrolments.

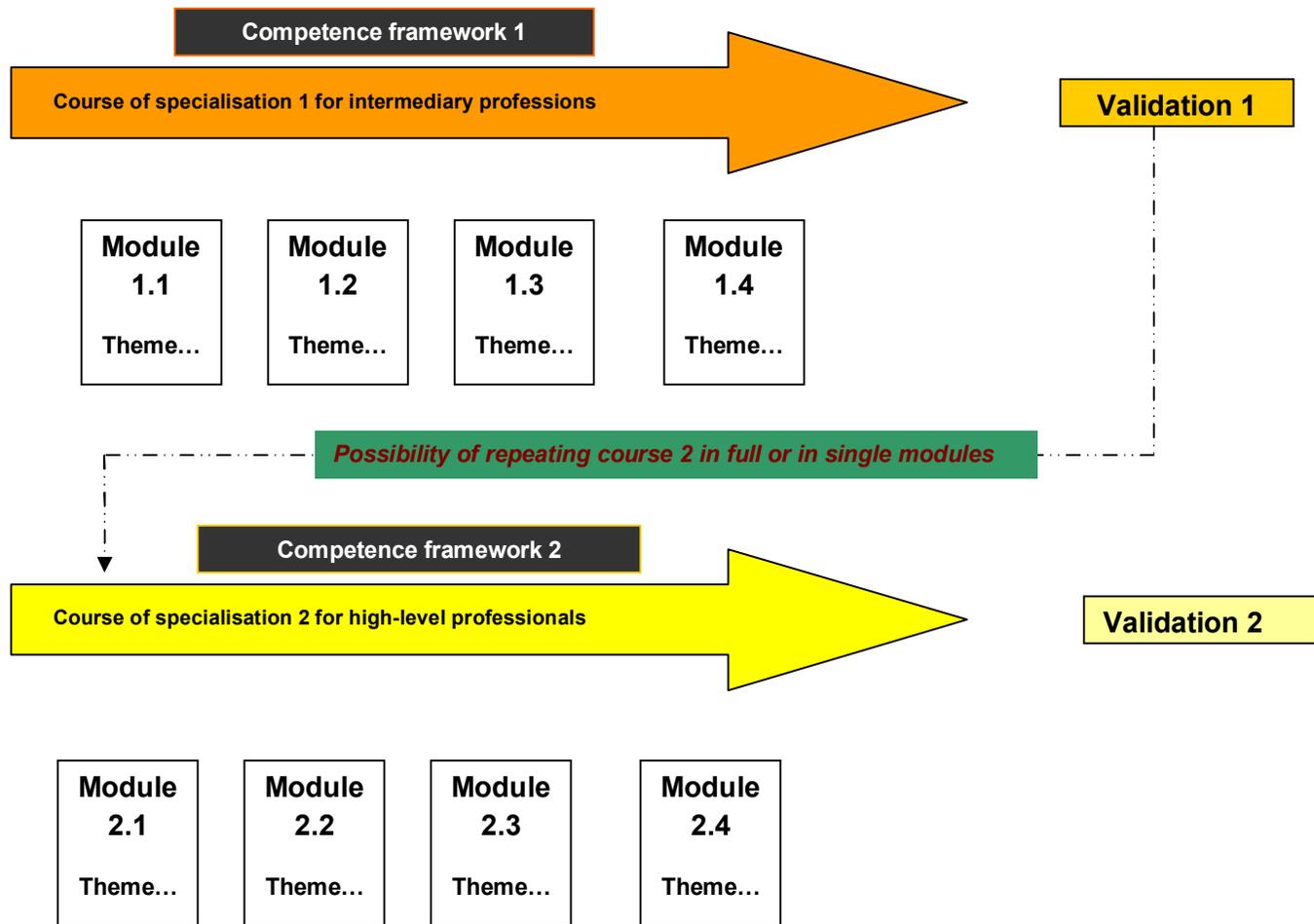
***Summary: with regard to the engineering of the “ABI” project, Arceau Anjou has suggested developing 2 separate courses of specialisation to ensure that the training needs of all ABI professionals are met. These 2 courses would be available to participants on completion of a common module, open to all professionals regardless of basic training and experience.***

**Diagram to follow ↷**

**Common general knowledge module / 5 days**

**Objectives:** Address the specific needs arising from different disabilities. Improve professional behaviour through a better understanding of ABI patients.

**Content:**  
 Anatomy and pathological aspects.  
 Various sequelae and their repercussions.  
 Different professions and the links between them.  
 Made-to-measure, multidisciplinary action plans.  
 ICF and DCP.  
 User rights and positive treatment.  
 Regulatory measures.



## 8. REFERENCES

### Resources and methods used:

- ✚ 55 questionnaires on training needs, completed by various professionals
- ✚ 17 interviews with disabled people
- ✚ 21 training programmes analysed
- ✚ Participation of 14 “experts” in the national conference
- ✚ ISO and AFNOR standards on training quality

## 9. APPENDIXES

1. Training needs questionnaire (French and English versions)
2. Analysis of training needs (French version)
3. Inventory of existing training programmes (French version)
4. Training programme evaluation grid (French version)

## ANNEXE 1

### QUESTIONNAIRE RELATIF A L'ETUDE DES BESOINS DE FORMATION

Age:

\_\_\_\_\_

Sexe : M F

Formation:

\_\_\_\_\_

Nom de la structure dans  
laquelle vous travaillez

\_\_\_\_\_

Dans le domaine de l'accompagnement au long court des personnes victimes d'une lésion cérébrale acquise, un large éventail de connaissances est nécessaire. Merci de classer les différents domaines de connaissance inscrits ci dessous de 1 (celui que vous considérez le moins important) à 12 (celui que vous considérez le plus important). Nous savons que ce ne sera pas une tâche facile, mais merci d'essayer tout de même !

\_\_\_\_\_ L'anatomie du cerveau

\_\_\_\_\_ Le système sensoriel (vision, audition, goût, odorat...)

\_\_\_\_\_ Le système moteur (déplacements, mouvements)

\_\_\_\_\_ La cognition (mémoire, association d'idées,  
conceptualisation, langage, attention, perception,  
capacité à résoudre des situations problèmes...

\_\_\_\_\_ Les émotions (capacités physiques et mentales en lien  
avec une large variété de sentiments, réflexions, et  
comportements)

\_\_\_\_\_ Le comportement

\_\_\_\_\_ Les apprentissages

\_\_\_\_\_ L'insertion au sein de la société

\_\_\_\_\_ La créativité

\_\_\_\_\_ La place de la famille

\_\_\_\_\_ La législation

\_\_\_\_\_ Les soins médicaux

\_\_\_\_\_

Classer les différents chapitres des domaines cités ci-dessous, de 1 à 4, selon que la connaissance est nécessaire pour travailler avec des personnes victimes d'une lésion cérébrale. Merci de noter le domaine de connaissance que vous considérez comme le plus important avec le N° 1, continuer avec les N° 2 pour le domaine que vous considérez comme le plus important ensuite, etc. Nous savons que ce ne sera pas une tâche facile, mais merci d'essayer tout de même !

Ensuite, noter votre connaissance dans chacun de ces domaines avec la note de 1, 2, 3, 4 ou 5

(1 : Insuffisant, 2 : suffisant, 3 : bon, 4 : très bon, 5 : excellent). Cocher la note correspondante.

Enfin, noter avec une croix la manière dont vous souhaiteriez que ce domaine soit abordé lors de votre formation (en pourcentage). La somme de théorie et pratique doit être égale à 100%.

### **L'anatomie du cerveau :**

Classer	Note
La structure du cerveau	1 2 3 4 5
Les fonctions du cerveau	1 2 3 4 5
La vascularisation du système nerveux central	1 2 3 4 5
La stimulation du cerveau	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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### **Le système sensoriel :**

Classer	Note
Le système sensoriel et les troubles associés	1 2 3 4 5
L'origine des troubles sensoriels	1 2 3 4 5
La prise en charge des personnes présentant des troubles sensoriels	1 2 3 4 5
Les répercussions des troubles sensoriels sur le fonctionnement global de la personne.	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## Le système moteur :

Classer	Note
Le système moteur et les troubles associés	1 2 3 4 5
L'origine des troubles moteurs	1 2 3 4 5
La prise en charge des personnes présentant des troubles moteurs	1 2 3 4 5
Les répercussions des troubles moteurs sur le fonctionnement global de la personne.	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## La cognition :

Classer	Note
La cognition et les troubles associés	1 2 3 4 5
L'origine des troubles cognitifs	1 2 3 4 5
La prise en charge des personnes présentant des troubles cognitifs	1 2 3 4 5
Les répercussions des troubles cognitifs sur le fonctionnement global de la personne.	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## Les émotions :

Classer	Note				
Les émotions et les troubles associés	1	2	3	4	5
L'origine des troubles affectifs	1	2	3	4	5
La prise en charge des personnes présentant des troubles affectifs	1	2	3	4	5
Les répercussions des troubles affectifs sur le fonctionnement global de la personne.	1	2	3	4	5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## Le comportement :

Classer	Note				
Le comportement et les troubles associés	1	2	3	4	5
Les origines des troubles du comportement	1	2	3	4	5
La prise en charge des personnes présentant des troubles du comportement	1	2	3	4	5
Les répercussions des troubles du comportement sur le fonctionnement global de la personne.	1	2	3	4	5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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**Les apprentissages :**

Classer	Note				
Méthodes et techniques	1	2	3	4	5
L'origine des difficultés d'apprentissage	1	2	3	4	5
L'importance des apprentissages dans les situations de la vie quotidienne	1	2	3	4	5
Les répercussions des difficultés d'apprentissage sur le fonctionnement global de la personne.	1	2	3	4	5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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**Insertion au sein de la société :**

Classer	Note				
L'accompagnement à l'insertion au sein de la société	1	2	3	4	5
Les origines du besoin d'être inséré au sein d'une société	1	2	3	4	5
Les difficultés d'insertion au sein de la société	1	2	3	4	5
Les répercussions de l'insertion sur le fonctionnement global de la personne.	1	2	3	4	5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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### La créativité :

Classer	Note
Ce qu'est la créativité	1 2 3 4 5
Les origines du besoin de l'expression par la créativité	1 2 3 4 5
Les méthodes adaptées pour l'expression de la créativité	1 2 3 4 5
Les répercussions du processus créatif sur le fonctionnement global de la personne.	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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### La place des proches :

Classer	Note
Droits de la famille	1 2 3 4 5
Les techniques de médiation dans le travail avec les proches	1 2 3 4 5
Les problématiques spécifiques rencontrées par les proches des victimes d'une lésion cérébrale acquise	1 2 3 4 5
L'impact de la famille sur le fonctionnement global de la personne.	1 2 3 4 5

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## La législation :

Classer	Note					
Le statut des personnes victimes d'une lésion cérébrale acquise	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
Les dispositifs légaux pour la protection des individus et de leurs biens	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
L'évaluation des risques juridiques liés à la responsabilité morale	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
Peines encourues en cas de violation de la loi	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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## Les soins médicaux:

Classer	Note					
Vivre sainement	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
L'hygiène	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
L'évaluation et la réalisation des soins médicaux	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		
Les répercussions des soins sur le fonctionnement global de la personne.	<table border="1"><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	1	2	3	4	5
1	2	3	4	5		

Théorie	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Pratique	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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**ANNEXE 2**  
**ETUDE SUR LES BESOINS DE FORMATION**

**Document joint**

FORMATIONS DIPLOMANTES	
Intitulé	Structure
Diplôme Universitaire « traumatismes crânio-cérébraux : aspects médicaux et sociaux »	Faculté de médecine Montpellier 1
Diplôme Inter Universitaire « traumatismes crânio-cérébraux : aspects médicaux et sociaux »	Université de Versailles, de Bordeaux 2 et d'Angers
Diplôme Universitaire prise en charge des patients en état végétatif ou pauci-relationnel	Faculté de médecine St Etienne
Diplôme Universitaire « traumatisme crânien de l'enfant et de l'adolescent »	Facultés Paris et Aix en Provence
Diplôme Inter Universitaire « évaluation des traumatismes du crâne »	Faculté Versailles St Quentin et Bordeaux 2

FORMATIONS NON DIPLOMANTES	
Intitulé	Structure
Conséquences d'une lésion cérébrale acquise sur les activités de la vie quotidienne (Profil AVQ)	ANFE/ Arcueil
PEC des pratiques de déplacements du traumatisé crânien à l'étape de la réinsertion socio-prof	ADAMS/ Bordeaux
Stratégies de développement d'une offre d'assistance spécialisée pour traumatisés crâniens dans 1 filière de soins ou dans 1 service d'aides humaines	ADAMS/ Bordeaux
L'accueil des traumatisés crâniens en institution : "du projet de vie au projet d'établissement"	ADAMS/ Bordeaux
L'aide humaine dans la réinsertion sociale du traumatisé crânien à la phase séquellaire. Mise en place d'1 assistance dans le projet de vie (niveau. 1)	ADAMS/ Bordeaux
Problématiques et enjeux de la réinsertion sociale du traumatisé crânien à la phase séquellaire	ADAMS/ Bordeaux
Evaluation de l'impact des séquelles du traumatisé crânien dans la vie quotidienne et sociale pour l'élaboration du projet de vie	ADAMS/ Bordeaux
La mise en œuvre du projet de vie alternatif au placement ou au retour au domicile parental	ADAMS/ Bordeaux
Les personnes victimes d'un traumatisme crânien : aspects médicaux, psychologiques, psychiatriques	APF/Paris
Accompagner les personnes victimes d'un traumatisme crânien	APF/Paris
Difficultés mnésiques et traumatisme crânien	APF/ Bordeaux
De l'éveil de coma à la réinsertion du traumatisé crânien	ADAPT/ Cénac
La personne cérébrolésée et son environnement	ADAPT/Paris
La réinsertion du traumatisé crânien grave : définir 1 projet de vie et sa réalisation	ADAPT/Cénac
Les patients pauci-relationnel ou en EVC	ADAPT/Cénac
Les troubles du comportement suite à LCA	ADAPT/Paris



Dispositif étudié :

Caractéristiques	Critères	++	+	-	--	Commentaires et axes à retenir
<b>Clients visés :</b>	<ul style="list-style-type: none"> <li>- Hétérogénéité</li> <li>- Homogénéité</li> <li>- Pré-requis</li> </ul>					
<b>Finalité</b>	<ul style="list-style-type: none"> <li>- Annoncée ?</li> <li>- Centrée sur les besoins de la filière ?</li> <li>- Centré sur les besoins de la filière ?</li> </ul>					
<b>Professionalisme attendu</b> (en termes d'objectifs de capacités)	<ul style="list-style-type: none"> <li>- Annoncé clairement à travers des capacités visées ?</li> </ul>					
<b>Contenu de la formation</b>	<ul style="list-style-type: none"> <li>- Spécialiste/généraliste ?</li> <li>- Suffisamment détaillée ?</li> <li>- En lien avec le professionnalisme visé ?</li> <li>- Répartition équilibrée des thèmes</li> <li>- Actualisé selon les évolutions du secteur ?</li> </ul>					
<b>Modalités</b> (intra/inter- alternance- durée- volume- axes pratiques- méthodes et supports- validation et reconnaissance)	<ul style="list-style-type: none"> <li>- Cohérentes avec la situation des clients ?</li> <li>- Cohérentes avec les besoins des clients ?</li> <li>- Cohérentes avec les objectifs</li> <li>- Permettent l'atteinte des objectifs ?</li> </ul>					
<b>Equipe pédagogique</b>	<ul style="list-style-type: none"> <li>- Représentative de la filière ?</li> <li>- Qualités des références professionnelles ?</li> <li>- Coordination de l'équipe ?</li> </ul>					
<b>Information sur la formation</b>	<ul style="list-style-type: none"> <li>- Accessible ?</li> <li>- Attractive ?</li> <li>- Actualisée ?</li> </ul>					
<b>Modalités pratiques</b> (lieux, dates et horaires)	<ul style="list-style-type: none"> <li>- Souplesse</li> <li>- Accessibilité/proximité</li> </ul>					
<b>Coût</b>	<ul style="list-style-type: none"> <li>- Accessible</li> <li>- Clarté de l'offre</li> </ul>					