FIX SMALL
ART

Swedish Council for
Higher Education

GUIDE TO WORK WITH DISABLED PEOPLE AND MENTALLY ILL IN ARTS

Trainers and Experts Materials

Part of Output 2
“Inclusive art for disabled people and mentally” (FIXSMALLART)
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FIX SMALL ART

Project Overview

The main objective of the project **Fix Small Art** is to examine and moderate different **art methods** and **techniques** supporting social tolerance practices in adult education for people with learning disabilities and mental illness, helping their social and personal empowerment by enhancing the training skills of their teachers. The project supports the **social workers and trainers** to create and connect art techniques with training methodologies making possible the empowerment of people with learning disabilities and mental health so they can improve their communication skills, social status and personal responsibility.

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CHAPTER 1: DISABILITY

Introduction

Disability is a normal part of human diversity. Disability may be **permanent, temporary or fluctuating**, and may have a minimal or substantial impact on a person's life. Disability may impact mobility, learning or communication and can result from accident, illness or genetic conditions***. Disability does not just refer to a person's health or wellbeing***. It involves the interaction between the unique features and functions of a person's body and mind and the environment and socio-political context in which they live. Disability does not equate to inability to achieve. People with disability have the same right as everyone else to make decisions for their own lives and to be active members of society.

Disability forms only a part of an individual's identity. While some people identify strongly with their disability**, others may see it as just another part of what makes them unique.** The Commonwealth Disability Discrimination Act (1992) defines 'disability' in relation to a person as:

a) Total or partial loss of the person's bodily or mental functions; or

b) Total or partial loss of a part of the body; or

c) The presence in the body of organisms causing disease or illness; or

d) The presence in the body of organisms capable of causing disease or illness; or

e) The malfunction, malformation or disfigurement of a part of a person's body; or

f) A disorder of malfunction that results in the person learning differently from a person without the disorder or malfunction; or

g) A disorder, illness or disease that affects a person's thought processes, perceptions of reality, emotions or judgment or that results in disturbed behavior, and includes a disability that: presently exists; or previously existed but no longer exists; or May exist in the future; or Is imputed to a person.

What counts as a disability?

There is no definitive classification system for disability. Disability is a normal part of human diversity. You may be affected temporarily, permanently or have symptoms that occur from time to time. Your disability may include one or more of the following:

Attention Deficit Disorder	Anxiety disorder (including Obsessive Compulsive Disorder)	Autism spectrum (including Asperger’s Syndrome)	Neurological condition	Post-Traumatic Stress Disorder
Depressive disorder	Hearing impairment	Learning disability	Physical disability	Psychological condition
Eating disorder	Vision impairment	Medical condition	Psychiatric condition	Psychotic disorder

Disability is not always visible or singular, for example, an individual who has cerebral palsy may also experience a mental health condition such as anxiety or someone with vision impairment may also have a learning disability. Depending on the severity of your condition, you may require long or short-term assistance with any of the above.

Definition of terms

Accessibility: *The degree to which a building or other structure provides access for (mainly physically) disabled people. In Singapore, this is determined primarily by the Building and Construction Authority’s Code on Accessibility in the Built Environment.*

Accessible: *In the case of a facility, readily usable by a person with disabilities (PWD); in the case of a program or activity, presented or provided in such a way that a PWD can participate, with or without auxiliary aid(s); in the case of electronic resources, accessible with or without assistive computer technology.*

Augmentative and alternative communication (ACC): *Type of communication that combines gestures, eye pointing, vocalization and pointing to symbols as communication for people with limited speech ability. Parts of ACC are signing, object symbols - photos, drawings and symbols-communication boards and displays- chat books- speech generated devices- communication books –* natural communication methods

ADHD / Attention Deficit Hyperactivity: *This term now includes ADD / Attention Deficit Disorder - a disorder that appears in early childhood. ADHD makes it difficult for people to inhibit their spontaneous responses (responses can involve everything from movement to speech to attentiveness).*

Stigma: *In other fields, such as mental health and HIV/AIDS, the term ‘**stigma**’ has been used in preference to ‘**attitudes**’. The term originates in ancient Greek and was reintroduced into common parlance in the 1960s by Goffman who defined stigma as the process by which the reaction of others spoils normal identity. More recently, stigma has been conceptualized as the co-occurrence of these stigma components: labeling, stereotyping (that is negative evaluation of a label), prejudice (that is endorsement of negative stereotypes), which lead to status loss and discrimination for the stigmatized individual or group.*

Discrimination *is a behavioral response to prejudice and can include the withholding of help, opportunities and access to, for example, employment and housing but also avoidance of people. Importantly, for stigmatization to occur, power must be exercised, a condition that is clearly met in the case of people with learning disabilities. The term stigma offers a distinct advantage of being more encompassing. In addition to a traditional, narrower understanding of attitudes (as mainly concerned with what people think but not with what they actually do), the concept of stigma invites us to explicitly* *focus on behavior (discrimination), and on the process and power relations involved in negative stereotyping and discrimination. However, we recognize that, to date, the term has rarely been used in the learning disabilities field. Hence, in this report we use the term attitudes when describing work in the learning disabilities field. At times, we intentionally make use of the term stigma to link to theory and evidence produced in other fields and to encourage us to learn from other fields, where appropriate.*

Learning disability: *a condition giving rise to learning difficulties, especially when not associated with physical disability.*

Attitudes, myths and misinformation

Attitudes are a psychological construct that refers to favorable or unfavorable evaluations of people, objects, places or activities. They are made up of three *aspects:* ***a cognitive component*** (how we think about X), ***an emotional component*** (how we feel about X), and a ***behavioral component*** (how we act towards X). While contemporary psychological definitions encompass these three aspects, in common parlance the term 'attitudes' is mostly used to refer to the cognitive component alone, and less so to emotions and actions or behaviors. A simple part of being human is that we develop attitudes about people, objects and activities we are exposed to in life. Many of these involve quick responses and are neutral or positive. Accordingly, when we refer to attitudes that limit the rights and opportunities afforded to people with learning disabilities, we should strictly refer to 'negative attitudes' that we wish to tackle, or conversely '**positive attitudes'** that we wish to increase or spread.

Recent research distinguishes between **explicit and implicit attitudes**. Explicit attitudes are *evaluations that are consciously available to the person holding them and are generally measured through questionnaires,* whereby respondents self-report what they think, feel or intend to do. In contrast, implicit attitudes are said to be *largely outside of conscious awareness and are typically measured in timed word sorting tests that assess whether a respondent shows an implicit positive or negative bias towards a category, such as* '**learning disability'**. While self-report attitude measures are at risk of inviting responses that are socially desirable, yet may bear little relation to someone's true values, implicit attitude tests are fairly robust against faking (although not immune to it). Recent evidence suggests that explicit and implicit attitude measures jointly provide the best prediction of behavior. To date implicit attitude measures have only been used in a handful of studies in the learning disabilities field. For socially sensitive topics, which one may presume attitudes to disability fall under, explicit measures provide particularly poor predictions of behavior, while implicit measures provide a better indication of someone's behavior.

The first question facing any attempt to ***tackle negative attitudes and discrimination*** directed at people with learning disabilities is who to target. Possible targets include the *general public, the media, those influencing legislation, policy and law enforcement, employers, and groups most likely to have contact with children and adults with learning disabilities, such as children and young people in inclusive schools, teachers, health and social care providers, careers, co-workers, and neighbors of supported living schemes, or indeed parents and siblings of people with learning disabilities*. Direct contact with people with learning disabilities as a route to attitude change has been employed as part of student training programmes. Such programmes have included activities such as didactic teaching, discussion, disability awareness tasks and workshop exercises led by a facilitator with learning disabilities. Another study provided interpersonal contact by getting students to house and entertains individuals with learning disabilities and their support staff over a 2.5-day period. In other studies, the impact of volunteering at sporting events, especially via the Special Olympics, on volunteers' attitudes was examined. This contact-based intervention mostly showed positive effects on attitudes, but because they target volunteers could be seen as "preaching to the converted". Given that in many instances it may be difficult to provide direct contact, and control the quality of that contact, some attempts have been made to use indirect contact, for example through film-based interventions, to improve attitudes. Studies that examined indirect contact with individuals with learning disabilities have simulated contact through the use of photographs and films with documentary or drama footage delivered to participants in a classroom or experimental site, or via the internet. Another means of indirect contact has used experiential learning by having student teachers interview families of children with disabilities.

An important route to **influencing attitudes** of the public and those who may have few opportunities for interacting with people with learning disabilities is through the media. Guidance for the media on portrayals of people with learning disabilities has emphasized the need to present them in realistic terms, not just as victims or heroes in the face of adversity, to show them in roles not defined by their disability and involve them directly in programming. There are few data on the use of such guides by media personnel or the impact of this guidance when it is implemented. Although the very low proportion of people with learning disabilities who are in some form of employment is a big concern, surprisingly few studies have been reported that attempt to change attitudes among employers or coworkers. This may reflect an institutionalized perception that people with learning disabilities really cannot work or are not a priority in addressing employment discrimination.

Few would question that placing children with learning and other disabilities alongside their peers without disabilities within **inclusive schools** is important in principle and may also affect negative attitudes and discrimination. Accordingly, children and young people in inclusive schools may receive interventions aimed at raising disability awareness and reducing bullying, including work targeting bullying of peers with disabilities.

As indicated by the wide range of studies referred to above, numerous interventions from different parts of the world have been reported that loosely aim to change attitudes towards people with (learning) disabilities, including disability awareness and disability equality training, anti-bullying work in education settings, and a host of mostly small scale, isolated, contact-based interventions. Methodological limitation concerns the poor measurement of attitudes to people with learning disabilities. Most measures available fail to distinguish the three components of attitudes (cognition, affect and behavior). A recently developed measure, the **Attitudes toward Intellectual Disability (ATTID**) questionnaire, is a notable exception.

Finally, another crucial methodological limitation with existing research is that most studies have failed to test the impact of attitude change interventions on actual behavior. Although the effects of an intervention on behavior are much more difficult to measure than asking someone to complete a self-report questionnaire, it is how people behave in relation to individuals with learning disabilities that have perhaps the strongest effect on opportunities for equal participation in society. Studies that did consider change in behavioral intentions or actual behavior mostly found changes in knowledge and attitudes but there was often little indication that the intervention affected how someone acts or might act in real life interactions with people with learning disabilities.

Concerning conceptual limitations, many interventions have not been based in a coherent fashion on theories of attitude and attitude change, despite these being abundant in the field of social psychology. Without clear theoretical underpinnings that guide intervention design that is a statement of how attitude change is expected to happen, any changes observed are vulnerable to unconvincing, post-hoc explanations. Detailed consideration of attitude change theories is beyond the scope of this document. However, as noted earlier, interventions should pay close attention to the three components of attitudes and explicitly state at which of these the intervention is targeted and how change is projected to occur. Intergroup contact theory, or a version thereof that more closely represents ‘mere exposure’, appears to underpin many of the interventions in the learning disabilities field. However, theories that have informed attitude change in other fields, such as **attribution theory or social norms theory**, have found little attention in the learning disabilities field to date.

The difference is that barriers people with disabilities face begin with people's attitudes - attitudes often rooted in misinformation and misunderstandings about what it's like to live with a disability.

Myth 1: People with disabilities are brave and courageous. **Fact:** Adjusting to a disability requires adapting to a lifestyle, not bravery and courage.

Myth 2: Ail persons who use wheelchairs are chronically ill or sickly. **Fact:** The association between wheelchair use and illness may have evolved through hospitals using wheelchairs to transport sick people. A person may use a wheelchair for a variety of reasons, none of which may have-anything to do with lingering illness.

Myth 3: Wheelchair use is confining; people who use wheelchairs are "wheelchair-bound." **Fact:** A wheelchair, like a bicycle or an automobile, is a personal assistive device that enables someone to get around.

Myth 4: Ail persons with hearing disabilities can read lips. **Fact:** Lip-reading skills vary among people who use them and are never entirely reliable.

Myth 5: People who are blind acquire a "sixth sense." **Fact:** Although most people who are blind develop their remaining senses more fully, they do not have a "sixth sense."

Myth 6: People with disabilities are more comfortable with "their own kind." **Fact:** In the past, grouping people with disabilities in separate schools and institutions reinforced this misconception. Today, many people with disabilities take advantage of new opportunities to join mainstream society.

Myth 7: Non-disabled people are obligated to "take care of" people with disabilities. **Fact:** Anyone may help, but most people with disabilities prefer to be responsible for themselves.

Myth 8: Curious children should never ask people about their disabilities**. Fact**: Many children have a natural, uninhibited curiosity and may ask questions that some adults consider embarrassing. But scolding curious children may make them think having a disability is "wrong" or "bad." Most people with disabilities won't mind answering a child's question.

Myth 9: The lives of people with disabilities are totally different than the lives of people without disabilities. **Fact:** People with disabilities go to school, get married, work, have families, do laundry, grocery shop, laugh, cry, pay taxes, get angry, have prejudices, vote, plan and dream like everyone else.

Myth 10: It is all right for people without disabilities to park in accessible parking spaces, K only for a few minutes. **Fact:** Because accessible parking spaces are designed and situated to meet the needs of people who have disabilities, these spaces should only be used by people who need them.

Myth 11: Most people with disabilities cannot have sexual relationships. **Fact:** Anyone can have a sexual relationship by adapting the sexual activity. People with disabilities can have children naturally or through adoption. People with disabilities, like other people, are sexual beings.

Myth 12: People with disabilities always need help. **Fact:** Many-people with disabilities are independent and- capable of giving help. If you would like to help someone with a disability, ask if he or she needs it before you act.

Myth 13: There is nothing one person can do to help eliminate the barriers confronting people with disabilities. **Fact** Everyone can contribute to change. You can help remove barriers by:

- Understanding the need for accessible parking and leaving it for those who need it
- Encouraging participation of people with disabilities in community activities by using accessible meeting and event sites
- Understanding children's curiosity about disabilities and people who have them
- Advocating a barrier-free environment
- Speaking up when negative words or phrases are used about disability
- Writing producers and editors a note of support when they portray someone with a disability as a "regular person" in the media
- Accepting people with disabilities as individuals capable of the same needs and feelings as yourself, and hiring qualified disabled persons whenever possible

Language, terminology and behavior

Appropriate Terms to Use: When writing or speaking about people with disabilities it is important to put the person first. Catch-all phrases such as 'the blind', 'the deaf' or 'the disabled, do not reflect the individuality, equality or dignity of people with disabilities. Listed below are some recommendations for use when describing, speaking or writing about people with disabilities. Some examples of appropriate terms: Term no longer in use: the disabled Term Now Used: people with disabilities or disabled people

Wheelchair-bound →persons who uses a wheelchair;

confined to a wheelchair →wheelchair user;

cripple, spastic, victim →disabled person, person with a disability;

the handicapped→ disabled person, person with a disability;

mental handicap →intellectual disability;

mentally handicapped →intellectually disabled;

normal→ non-disabled;

schizo, mad→person with a mental health disability;

suffers from (e.g. asthma) →has (e.g. asthma)

Disability Etiquette

People with disabilities are entitled to the same courtesies you would extend to anyone, including personal privacy. If you find it inappropriate to ask people about their sex lives, or their complexions, or their incomes, extend the courtesy to people with disabilities.

- If you don't make a habit of leaning or hanging on people, don't lean or hang on someone's wheelchair. Wheelchairs are an extension of personal space.
- When you offer to assist someone with vision impairment, allow the person to take your arm. This will help you to guide, rather than propel or lead, the person.
- Treat adults as adults. Call a person by his or her first name only when you extend this familiarity to everyone present. Don't patronize people who use wheelchairs by patting them on the head. Reserve this sign of affection for children.

In conversation

- When talking with-someone who- has a disability, speak directly to him or her, rather than through a companion who may be along.
- Relax. Don't be embarrassed if you happen to use common expressions, such as "See you later" or "I've got to run", that seem to relate to the person's disability.
- To get the attention of a person who has a hearing disability, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. Not everyone with hearing impairments can lip-read. Those who do will rely on facial expressions and other body language to help understand. Show consideration by facing a light source and keeping your hands and food away from your mouth when speaking. Keep mustaches well-trimmed. Shouting won't help, but written notes will.
- When talking with a person in a wheelchair for more than a few minutes, place yourself at the wheelchair user's eye level to spare both of you a stiff neck.
- When greeting a person with a severe loss of vision, always identify yourself and others who may be with you. Say, for example, "On my right is Andy Clark". When conversing in a group, remember to say the name of the person to whom you are speaking to give vocal cue. Speak in a normal tone of voice, indicate when you move from one place to another, and let it be known when the conversation is at an end.
- Give whole, unhurried attention when you're talking to a person who has difficulty speaking. Keep your manner encouraging rather than correcting and be patient rather than speak for the person. When necessary, ask questions that require short answers or a nod or shake of the head. Never pretend to understand if you are having difficulty doing so. Repeat what you understand. The person's reaction will guide you to understanding.

Common courtesies...

- If you would like to help someone with a disability, ask if he or she needs it before you act, and listen to any instructions the person may want to give.
- When giving directions to a person in a wheelchair, consider distance, weather conditions and physical obstacles such as stairs, curbs and steep hills.
- When directing a person with a visual impairment, use specifics such as "left a hundred feet" or "right two yards".
- Be considerate of the extra time it might take a person with a disability to get things done or said. Let the person set the pace in walking and talking.
- When planning events involving persons with disabilities, consider their needs ahead of time. If an insurmountable barrier exists, let them know about it prior to the event.

Meeting disabled people, you should:

- Not make assumptions about the presence/absence/effect of an impairment

- Communicate in advance of the meeting (if possible)
- Offer assistance
- Ask what kind of assistance would be most useful
- Avoid giving assistance before your offer has been accepted
- Not be offended if your assistance is refused
- Listen to the person's instructions/comments
- Make physical contact where this is appropriate e.g. guiding the hand of a blind person to the back of the chair, offering your arm if they ask you to guide them
- Talk directly to the disabled person and not through a third party: 'does s/he take sugar
- Speak clearly: don't shout
- Make eye contact
- Respect confidentiality, privacy and personal boundaries/space

Activity

Disability awareness training

General discussion always helps to give insights into how to interact with disabled people. Even after participating in training, it is always advisable to check with the disabled person as to what would be most helpful. Some specific training may be needed: e.g. how to guide a blind person or the use of sign language.

An example of a training session

Two trainers: one disabled

1. in small groups: 15 minutes discussion on basic communication strategies with a deaf student who used lip reading. Note points on flipchart.

2. Plenary session: the following points were noted:

Face student when talking - Speak words clearly - Attract student's attention before speaking - Keep objects/hands away from the face - Don't turn the lights off in lecture room - Try to control background noise - Provide lecture materials in advance- During demonstrations the students can either look at what you are doing OR what you are saying – not both - Facilitate the use of support worker/note taker in class if required- Student to give feedback on accessibility of future classes- Practice to be modified accordingly

An example of hangout for defining stigma

1. Ask students if they know what the word "stigma" is means
2. Present different definitions of "stigma" taken from different historical periods

3. Lead a whole class discussion of the definition of "stigma" and the relationship between stigma, stereotyping and discrimination

An example for examining attitudes

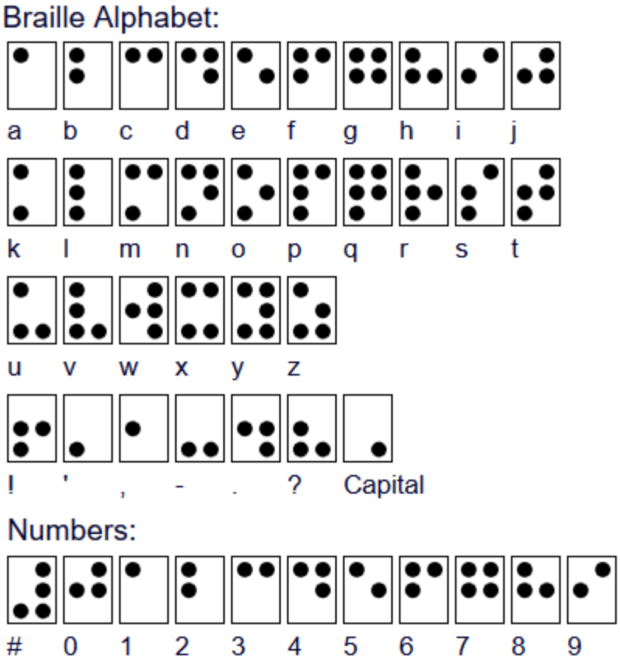
1. Handout Activity survey - Personal attitudes Survey
2. Ask the participants to complete the personal attitudes survey individually
3. Using a show of hands, compile the results of the survey on the board. Have students record the class results on their handout.
4. Ask students to share some general observations about the group's results. For example, only half the people surveyed agreed that they would have someone with a mental illness as a close friend; most people believe that medication for life is the best treatment.
5. Review the results of the class survey by comparing the results with the Activity Resource—Personal Attitudes Survey: Best Answers. Facilitate a class wide discussion about the survey results, highlighting items that may be surprising to the group

An example Reducing Stigma

1. Hand out Activity Handout—Reducing Stigma—What Works?
2. Encourage students to apply the strategies for reducing stigma in the school, at home and in the community.
3. Remind students that things have improved since the days of the "looney bin"; however, there are still many examples of people living with mental illness being portrayed as violent and ridiculed in the media and popular culture. Have students think about topical stories from the news, movies and TV shows.

Activity for Braille

Braille is a system of raised dots that can be read with the fingers by people who are blind or who have low vision. Teachers, parents, and others who are not visually impaired ordinarily read braille with their eyes. Braille is not a language. Rather, it is a code by which many languages—such as English, Spanish, Arabic, Chinese, and dozens of others—may be written and read. Braille is used by thousands of people all over the world in their native languages and provides a means of literacy for all.
Braille symbols are formed within units of space known as braille cells. A full braille cell consists of six raised dots arranged in two parallel rows each having three dots. The dot positions are identified by numbers from one through six. Sixty-four combinations are possible using one or more of these six dots. A single cell can be used to represent an alphabet letter, number, punctuation mark, or even a whole word.



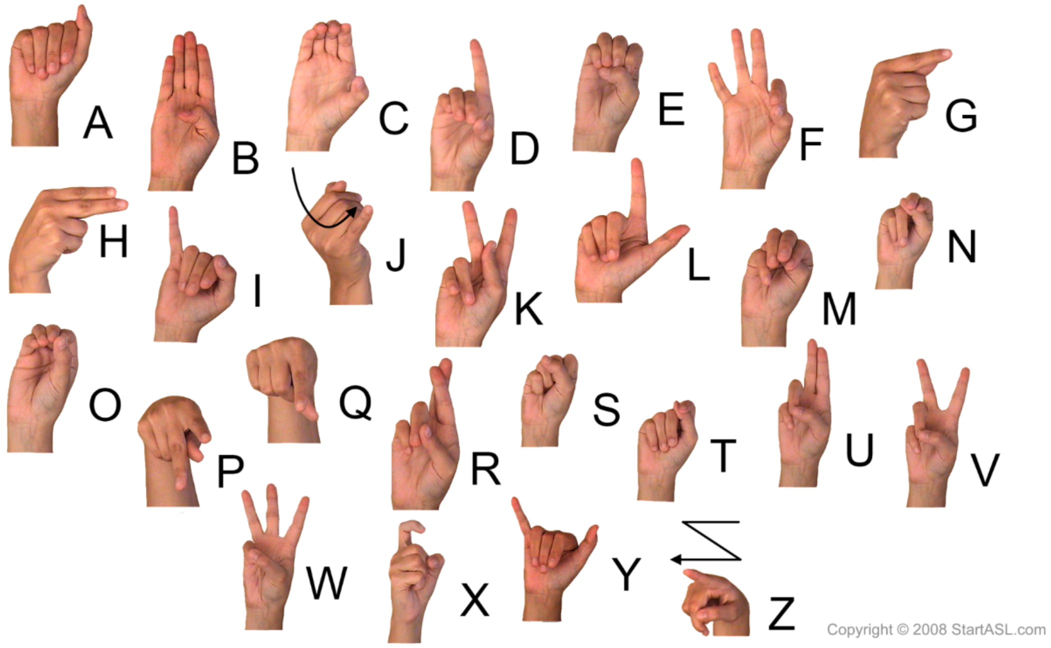
Learning is available here: https://www.youtube.com/watch?v=sqQ3gdE7ks0

Games with Braille: https://www.royalblind.org/national-braille-week/braille-resources/games-and-worksheets

Sign language:

Sign languages (also known as signed languages) are languages that use the visual-manual modality to convey meaning. Language is expressed via the manual signstream in combination with non-manual elements. Sign languages are full-fledged natural languages with their own grammar and lexicon. This means that sign languages are not universal, and they are not mutually intelligible, although there are also striking similarities among sign languages. Linguists consider both spoken and signed communication to be types of natural language, meaning that both emerged through an abstract, protracted aging process and evolved over time without meticulous planning. Sign language should not be confused with body language, a type of nonverbal communication. Wherever communities of deaf people exist, sign languages have developed as handy means of communication and they form the core of local deaf cultures. Although signing is used primarily by the deaf and hard of hearing, it is also used by hearing individuals, such as those unable to physically speak, those who have trouble with spoken language due to a disability or condition (augmentative and alternative communication), or those with deaf family members, such as children of deaf adults.

Signs:



Good practice Title	Project Implicit Mental Health (PIMH)
Country	**Harvard University, USA**
Type of practice*	Methodology
Included target groups	people that are measuring their mental health situation
Requirements	Not applicable
Description of practice	Project Implicit is a non-profit organization and international collaborative network of researchers investigating implicit social cognition - thoughts and feelings that are largely outside of conscious awareness and control. Project Implicit is the product of a team of scientists whose research produced new ways of understanding attitudes, stereotypes and other hidden biases that influence perception, judgment, and action. Implicit Bias Assessments https://implicit.harvard.edu/implicit/user/pimh/index.jsp https://implicit.harvard.edu/implicit/user/pimh/selectastudy.html
Benefits for target group	Preparing simple tests for testing the following main situations: • **Mental illness IAT:** Do you implicitly think people with metal health illness are dangerous?
Source of funding	Not applicable
Additional	Not applicable

comments	

Good practice Title	**Follow the White Rabbit** **2015-3-IT03-KA105-007105**
Country	**Italy**
Type of practice*	**Therapeutic use of agricultural practices**
Included target groups	**Disable people**
Requirements	**Not applicable**
Description of practice	In this project we can offer two different tasks that will be structured as follows:Activity number 1. Start in April 2016. 4 volunteers will rotate witha balanced sheet between the farm and social day center Passepartout1) Social Farm (Viterbo) - ALICE. Volunteers will support Alice's staff in helping, supporting and controlling the activities of people with mental illness or following recovery paths (usually young adults or adults). Together they participate in normal activities on the farm: planting and harvest vegetables, animal care, selling the prodcuts in the farm shop or helping with the preparation of G.A.S., Italian acronim for ethical purchasing groups, manual jobs such as the maintenance of the greenhouse.2) The center of Montefiascone Passepartout is designed to accommodate people with mental disabilities and Down syndrome. In the center volunteers will have the opportunity to participate in many types of activities: art workshops, painting, drawing, recycling workshop, cooking, sports, for there is also plenty of space for outdoor activities. In the day center the volunteer may propose activities or laboratories, using his skills and expertise in favor of the cooperative. Always in Montefiascone Alice manages the nonsolocavallo equestrian center where the volunteers, if they wish, can help in pet therapy activities on Tuesday or Friday afternoon.Activities start number 2. Start in June 2016. 4 volunteers, 2 for activities that will rotate every three months. In this way the volunteers can do activities with everyone and can experience the farm in two different seasons, which makes sense especially in the farm.1) Farm Montalto di Castro: ORTOSTORTO. Therapeutic use of agricultural practices. In the social farm the normal activities are to provide health, social services or education for a number of vulnerable groups and provide a supervised, structured program of agricultural activities. Volunteer will work with people who have mental illness. Here are also the activities connected with the pet therapy and sports and outdoor activities.2) Second type of activity is host in a youth center CAG Tarquinia, where cooperative Alice runs a rehabilitation center for mental illnesses and physical. Here Alice is involved in the organization of creative workshops and artistic, in order to support social activities in favor of disabled people. There will be two types of activity, one is an art workshop and this year will be strongly linked to painting and a workshop to develop

	autonomy (every year is different and this year theme will be theater). Also in this secodn activity we can organize shifts for nonsolocavallo.The activities on farms are mostly similar however the users of the two farms are different, as in the farm of Viterbo there are mostly people with cognitive delays and rehabilitation from addictions. In Ortostorto at Montalto users is represented by persons with Down syndrome and patients with psychiatric syndromes. The farm of Viterbo is also a sales center, where volunteers can do business and help operators to manage the purchasing groups. Recently they have also a laboratory for processing products which volunteers will have the opportunity to see and experience.A Montalto activities are mainly focused in agricultural production, there is the part about transformation but on the other hand there are the animals that produce milk and a small processing workshop of dairy products.The two centers instead are completely different, Cag in Tarquinia hosts disabled with psychiatric disorders and motor but the afternoon is open to young people because it ia also a youth center. There is a rehearsal room, a multimedia room and a computer.In Passepartout Montefiascone there are adults with mental disabilities and Down syndrome. We organize many workshops, there is space for the development of a personal project for the volunteer and for outdoor activities.
Benefits for target group	**The aim of social farming is to promote mental and physical health by giving people the opportunity to spend time to work on the land.**
Source of funding	**Erasmus + Learning Mobility of Individuals**
Additional comments	**Not applicable**

Good practice Title	Recognition and Validation of Acquired Skills for Disabled People 2014-1-PT01-KA202-000919
Country	**Portugal**
Type of practice*	methodology
Included target groups	People with disabilities face difficulties when accessing education and vocational training, particularly recognition of acquired skills, and when searching integration in the labour market when compared to other citizens of Europe.
Requirements	Not applicable
Description of practice	The aim of REVADIS project is to allow people with disabilities the same access to opportunities of education/training and access to the labour market by enabling them to enhance their professional qualifications and gain mobility in the European space. We propose to improve the offer in the area of recognition of acquired skills for people with disabilities by adapting 4 professionals referential to 5 different types of disabilities, a total of 20 new

	professional key skills referential involving testing and validation by a total of 120 people with disabilities throughout the European space. The adaption of the referential will be made to the population with cerebral palsy and other neurological-skeletal disabilities, mental illness, vision impairment, hearing impairments and intellectual disability. We will apply to this methodology the system of ECVET thus allowing these people to achieve a specific number of ECVET nomenclature transferable to all Europe. This experience will be anchored in a best practice by the Portuguese Ministry of Education and Ministry of Economics regarding the recognition of academic acquired skills that allowed hundreds of people with disabilities to obtain a diploma of the 9th grade. Based on this best practice we will adapt professional referential of recognition of acquired skills to people with disabilities making a statement we hope will proliferate among all State-Partners. The general activities are as following a) make a diagnosis of the needs in terms of professional areas in the countries involved with the help of social partners and labour unions and write a report based on the findings b) choose 4 professional referential and make the adaptations and apply the system of ECVET in order to create a common platform transferable throughout Europe c) test the referential and methodology applying them to all 5 groups of disability in a total of 120 persons with disabilities involved and write the referential and methodological guide d) implement strategies of dissemination to produce a cascade effect within the countries of the consortium and among partner institutions of Europe e) a Guide of recommendations will be published f) the consortium will make an evaluation of the work produced regarding the tasks and aims of the project. Methodology The expected quantitative results will be 20 new professional referential available with involvement of 120 persons with disability in its construction and testing. Two reports published with diagnosis of needs and recommendations and a methodological guide published on how to apply the system of recognition of skills to people with disabilities (all 3 in 5 different languages and English). More qualitative results are also expected: an affirmative evaluation of the referential by social partners and labour unions is required as they are crucial for the success of the project as is a positive evaluation of satisfaction of the people with disabilities involved and their families.
Benefits for target group	The impact to direct target-group: a) increasing of professional qualifications of the individuals with disabilities involved b) acquisition of new technical and social skills c) acquisition of labour market integration skills d) acquisition of mobility in the European labour market d) enhancement of self-esteem and motivation. The global impact will be: a) new 20 professional referential of recognition of acquired skills available in the training/education market b) implementation of system of ECVET to the recognition of acquired skills as a new step taken in education/training c) new methodology adapted specifically to disabled people d) involvement of social partners and labour

	unions in the area of recognition of acquired skills and disability e) know how on how to develop professional referential of recognition of skills adapted to disabled people. In longer term benefits the project will create a new dynamic regarding the application of recognition of acquired skills to people with disabilities and the utilization of ECVET that will more easily make the methodology flow among State-Partners. We believe it is an innovative project because it addresses specifically the recognition of skills applied to people with disabilities guaranteeing their access to the professional market with the same possibilities other citizens do and also by integrating the ECVET system we are taking it a step forward in promoting their possibilities of Inclusion in the European space.
Source of funding	Erasmus + Cooperation for innovation and the exchange of good practices
Additional comments	Not applicable

Conclusions

Disability is part of the human condition. Almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Most extended families have a disabled member, and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities.

Chapter 1 introduces the concept of disability and explores the attitudes, myths and misinformation about it. It also considers the perspective and prejudice by non-disabled people towards people with disability. Furthermore, Chapter 1 gives some basic tips to help anyone be more comfortable interacting with people with disabilities, and to help people with disabilities more enjoy interacting with non-disabled people. Including appropriate terminology and guidance on interacting with people with disabilities.

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CHAPTER 2 – LEGISLATION

The Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006 by the United Nations and entered into force in 2008, represents a new mindset in policies concerning disability and discrimination, promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. It recognizes persons with disabilities as subjects with rights, such as:

- Equality before the law without discrimination
- Right to life, liberty and security of the person
- Equal recognition before the law and legal capacity
- Freedom from torture
- Freedom from exploitation, violence and abuse
- Right to respect physical and mental integrity
- Freedom of movement and nationality
- Right to live in the community
- Freedom of expression and opinion
- Respect for privacy
- Respect for home and the family
- Right to education
- Right to health
- Right to work
- Right to adequate standard of living
- Right to participate in political and public life
- Right to participation in cultural life.

The Convention does not include new rights but identifies the specific actions that States must take to protect against discrimination on the basis of disability, promoting a cross-disability and cross-sectoral approach.

The Convention on the Rights of Persons with Disabilities promotes measures against "*Discrimination on the basis of disability*" understood as *"any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation*[1].

Although pre-existing human rights conventions, such as Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1994) and World Programme of Action on Disabled Persons (1982), represented an important starting point to promote the rights of persons with disabilities, they were not legally binding treaties and this implies that persons with disabilities continued being denied their human rights and were kept on the margins of society in all parts of the world.

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[1] *'Necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms'.*

On the contrary, the Convention includes legal obligations on States to promote and protect the rights of persons with disabilities, which can be grouped in three main typologies of human rights obligations:

- Respect – States Parties must: refrain from engaging in any act or practice that is inconsistent with the Convention; modify or abolish existing discriminatory laws, customs and practices; closely consult with and actively involve persons with disabilities in the development and implementation of legislation and policies to implement the Convention.
- Protect – States Parties must take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;
- Fulfil– Many of the specific obligations on States fall within this category. For example, States must adopt legislative, administrative, policy, programmatic and other measures to implement the rights of persons with disabilities; undertake or promote research and development into relevant goods and services, provide accessible information to persons with disabilities on relevant technology and other assistance, services and facilities; promote training of professionals and staff working with persons with disabilities.

Convention on the Rights of Persons with Disabilities – updated 2017

- 160 Signatories to the Convention
- 92 Signatories to the Optional Protocol
- 175 Ratifications to the Convention
- 92 Ratifications to both the Convention and the Optional Protocol

Legislation at European level

The European Union promotes the active inclusion and full participation of disabled people in society, in line with the EU human rights approach to disability issues and consistently with the UN Convention on the Rights of Persons with Disabilities, to which the EU is a party.

The Commission's European Disability Strategy 2010-2020 (2010) is one of the main initiatives adopted in Europe concerning these issues and it promotes **actions in eight priority areas: Accessibility; Participation**; **Equality**; **Employment**; **Education and training**; **Social protection**; **Health**; **External action**.

According to a review carried out by the Academic Network of European Disability Experts (ANED) - established by the European Commission in 2008 to provide scientific support to the development of the EU Disability Strategy and practical implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) -, disability is being mainstreamed in different areas of EU law and policy.

In order to exemplify the important and wide spread of legal and soft-law instruments at European level, we report here, for each area, only a selection of main documents which exemplify the multi-faceted measures promoted and implemented against discrimination based on disability[2].

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[2] For a complete review of documents see J. Arsenjeva (supervision of Professor L. Waddington), Annotated review of European Union law and policy with reference to disability, Academic Network of European Disability experts (ANED) February 2018

Accessibility

The European market is an area without frontiers where goods, services, persons and capital can move freely, according to different pieces of legislation, on which EU is competent. Declaration No. 22 to the Treaty of Amsterdam stipulates that in drawing up measures, “*the institutions of the Union shall take account of the needs of persons with a disability”.*

- *Directive on accessibility requirements for products and services (European Accessibility Act*) - European Commission (2015), which promotes accessible products and services at more competitive prices.
- *Communication on passenger rights in all transport modes* - European Commission (2011), which promotes accessibility and non-discrimination in transportation.
- *Digital Single Market Strategy* - European Commission (2015) – which does not explicitly address accessibility of ICTs for persons with disabilities, preferring instead to “an inclusive e-society” and “fight against discrimination against consumers”.
- *Audiovisual Media Services Directive* - European Parliament (2013) – which states that audiovisual commercial communications should not include or promote disability-based discrimination.

Participation

Several European legal instruments promote participation in the field of criminal proceedings, consumer affairs, mobility, culture for all citizens. In each area specific attention is paid to participation of persons with disabilities.

- First *eGovernment Action Plan* - European Commission (2016), which aims to modernize the public administration and engage with more citizens and businesses, according to the principles of inclusiveness and accessibility in designing digital public services.
- *Victims’ package* - European Commission (2011), which includes a number of relevant references to the rights of persons with disabilities who are victims of crimes.
- *European Consumer Agenda* - European Commission (2012), which identifies social exclusion and inaccessibility of products and services for vulnerable consumers (including those with disabilities) as economic and social challenges in the digital world.
- *EU-wide model for a parking card for people with disabilities* – European Council (2008), which allows people with disabilities to take advantage of the special parking facilities available in each Member State using their nationally issued card.
- *Regulation on the EU Agency for Railways* – European Parliament, European Council (2016), which provides that the Agency should consult the organizations representing railways customers and passengers, including representatives of persons with disabilities and reduced mobility.

- *European Copyright Directive* - European Commission (2012), which allows Member States to make exceptions from copyright regulations in respect of reproductions "for the benefit of people with a disability, which are directly related to the disability and of a non-commercial nature, to the extent required by the specific disability"

Equality

The primary law of the European Union became explicitly inclusive of persons with disabilities with the entry into force of the Amsterdam Treaty (1999), which introduced appropriate measures to combat discrimination on the ground of disability (among other grounds). This was seen as a formal commitment by the EU to fighting discrimination and working towards equality in Europe.

- Communication 'Equal opportunities for people with disabilities: A European Action Plan' COM (2003)650 - European Commission (2003), which promotes full implementation of the Employment Equality Directive, mainstreaming disability across all policy issues, and achieving accessibility for all
- Communication 'Equal opportunities for people with disabilities: A European Action Plan 2006-2007' COM (2005)604 – European Commission (2005), focuses on encouraging employment, access to support services, accessibility of goods and services, and data on discrimination
- Communication 'Equal opportunities for people with disabilities: A European Action Plan 2008-2009' COM (2007)738 – European Commission (2007), promotes inclusion through boosting accessibility of the labor market and of goods and services, and improving the Commission's analytical capacity to support accessibility
- *Treaty on the Functioning of the European Union (TFEU)* – European Parliament (2009), that stipulates that in "defining and implementing its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation".
- *European Union Charter of Fundamental Rights* - European Parliament, European Council, European Commission (2000), which contains a number of references to disability, became binding on the EU, and the Member States when implementing EU law.

Employment

The European strategy "Europe 2020: a strategy for smart, sustainable and inclusive growth" (2010) is the principal framework for actions aimed at creating a "social Europe" and it represents a reference point for the national targets, which are all relevant to persons with disabilities, who should benefit from both universal and targeted implementation measures set out in seven "flagship initiatives". The European Disability Strategy aims to ensure that the annual assessment of Europe 2020 gives due consideration to the situation of people with disabilities.

- *Equal Treatment Directive in employment and vocational training* - European Commission (2000), which aims at protecting the rights of disabled people in the field of employment and training.
- *Equal Treatment Directive outside employment* (proposed in 2008), aimed at extending the protection against discrimination based on disability, age, sexual orientation and religion outside the employment field.

Education and training

The strategic framework for European cooperation in education and training ET2020 adopted in 2008, does not mention disability explicitly, and nor do many other policy documents stemming from it. Several countries developed Disability Standards in the area of education, which set out the rights of students with disabilities in the area of education and the obligations of education providers such as schools and universities to assist students with disabilities. The main purpose of these standards is to ensure students with disabilities the right to participate in educational courses and programs on the same basis as students without disability, giving guidance on possible reasonable adjustments when required. An example is the Italian *CNUDD - Conferenza Nazionale Universitaria dei Delegati per la Disabilità*, a National commission created in 2001 in order to represent policies and activities of Italian univeristies addressed to students with disability and connected with disability issues. According to the Law 17/1999, in each University the Delegate on Disability is in charge of coordinating and monitoring all integration activities such as specialized tutoring, individual support, educational materials and ICT. Nevertheless, monitoring report in this area highlight the need to make European education and training more socially inclusive, including for learners with disabilities.

- *Conclusions on the social dimension of education and training* – European Council (2010) and *Conclusions on the Diversity to achieve a high-quality education for all* – European Council (2017), which stress that European education systems must respond to diversity and provide for the successful education of all learners, including those with disabilities.

Social protection

The Social Protection Committee, which consists of representatives from Member States, elaborated the so-called Open Method of Coordination (OMC), a means of voluntary cooperation in different areas, based on soft-law mechanisms, such as guidelines, indicators and sharing of best practice, which represents an important tool to advance social protection for disadvantaged groups. The Social Protection Committee publishes annual reports including available information about persons with disabilities, such as national trends in defining eligibility for disability benefits and availability of quality long-term care.

- *Social Investment Package* – European Commission (2013), which consists of several soft law measures for combating poverty and social exclusion, many of which directly target persons with disabilities.
- EU law includes a variety of *compensatory measures* to level out the situation of persons with disabilities by providing them with free or reduced-price services and tax incentives.

Health

At European level there are several documents which elaborate on the relationship between health and disability, identifying disability as a factor which increases the risk of health inequality, stating strategic objectives on mental health, promoting measures aimed at improving the lives of persons with disabilities or chronic illnesses who travel to another Member State to receive specialized medical treatment. Anyway, reporting often fails to assess the way the health systems address the health needs of persons with disabilities.

- *EU Strategy 'Together for health'* – European Commission (2007), which elaborates on the relationship between health and disability.
- *Communication on Solidarity in Health: Reducing Health Inequalities in the EU* – European Commission (2009), which recognizes disability as a factor which increases the risk of health inequality.

External action

The area of external action has seen a number of important developments following the entry into force of the CRPD that obliges the States Parties to take disability into account in all international cooperation work. The Guidance Note on Disability in Development for European Union Delegations and Services is a policy guidance on disability in development cooperation, produced by the European Union in 2004 and updated in 2012, which serves as a practical tool for EU delegations and builds on the recommendation of the earlier "Study of Disability in EC Development Cooperation".

- *European Consensus on Development* – European Council, the Member States, European Parliament, European Commission (2017), which aligns EU development policy to the UN Agenda 2030 for Sustainable Development.
- *Communication 'A decent life for all: ending poverty and giving the world a sustainable future'* - European Commission (2013), which refers to the European Disability Strategy 2010-2020 as the EU's contribution in the area of social protection, social inclusion and eradicating poverty.
- *2015 – 2019 Action Plan on Human Rights and Democracy* – European Council (2015), which promotes the rights of persons with disabilities in line with the EU's obligations under the Convention on the Rights of Persons with Disabilities.

Adequate funding

Legal obligations on States foreseen by the Convention on the Rights of Persons with Disabilities imply two different approaches:

- negative measures (to refrain from taking certain actions);
- positive measures (to adopt certain policies and programmes to promote the rights of persons with disabilities).

The implementation of positive measures might require financial and human resources, not available in all countries. Although the Convention recognizes this

specific situation and admits progressive development, lack of resources should not prevent States from implementing positive measures.
All States are supposed to:

- provide the bare minimum;
- to define priorities (measures and beneficiaries);
- to plan in order to implement in a more efficient and effective way.

The European Union adopted in 2013 the *Multiannual Financial Framework (MFF) 2014-2020,* which lays down the rules for spending up to EUR 959.99 billion in commitments and EUR 908.40 billion in payments over seven years. Resources are distributed across about 70 programmes, many of which are directly relevant to the implementation of the Convention on the Rights of Persons with Disabilities by the Union.
For example, the Structural Funds package 2014-2020, aimed at reducing economic and social inequalities between regions and social groups and accounting for the majority of EU spending, substantially reinforces the disability and accessibility provisions: accessibility for people with disabilities is one of the horizontal principles of Structural Funds; general rules of these funding programmes prohibit discrimination on the basis of disability in the preparation and implementation of activities; Member States are obliged to make sure that the initiatives financed under the Funds respect the Convention on the Rights of Persons with Disabilities; when appropriate, Member States should involve representative organizations of disabled people. The promotion of non-discrimination and of rights of persons with disability is also transversal to many *EU direct funds.*

Financial instruments such as *Regulation (EU) No 1303/2013, Regulation (EU) No 1301/2013, Regulation (EU) No 1304/2013, Regulation (EU) No 1288/2013, Regulation (EU) No 1295/2013, Regulation (EU) No 1291/2013, Regulation (EU) No 1287/2013, Regulation (EU) No 1316/2013, Regulation (EU) No 1381/2013, Regulation (EU) No 232/2014, Regulation (EU) No 231/2014, Regulation (EU) No 233/2014, Regulation (EU) No 235/2014, Regulation (EU) No 236/2014, Regulation (EU) No 516/2014, Regulation (EU) No 282/2014, Regulation (EU) No 254/2014* - European Parliament, European Council (2013), which prohibit disability discrimination in the implementation of the European Funds; promotes attention to the needs of persons with disabilities in small-scale infrastructures; take into account special learning needs of persons with disabilities; promote access by “disadvantaged and vulnerable groups” to the programmes; promote translational cultural exchange and mobility of artists with a particular focus on persons with disabilities; aim to improve the lifelong health and well-being for all; support entrepreneurs from “socially disadvantaged or vulnerable groups”, such as persons with disabilities; improve disability accessibility of transport; promote social and economic inclusion of persons with disabilities, protection of human rights of persons with disabilities, design and implementation of programmes and projects, criteria regarding accessibility for persons with disabilities.

Awareness raising

An important initiative for the development of the consolidated EU disability policy was the European Year of Persons with Disabilities 2003, which saw the adoption of the EU Disability Action Plan 2003-2010 and highlighted the process of negotiating of the future UN Disability Convention.

Some subsequent “European Years” (2007 European Year of Equal Opportunities, 2010 Year of Combating Poverty and Social Exclusion) also served to raise awareness about the rights of persons with disabilities.

Even though in recent years the interest towards this kind of initiatives has faded, European institutions made other attempts to promote awareness raising, for example with the Access City Award, (since 2010), aimed at ensuring accessibility of urban infrastructures and fundamental rights to all persons, regardless of age, mobility or disability.

Moreover, the European Law Academy promoted competences among legal practitioners on EU Anti-Discrimination Law, covering relevant issues, such as reasonable accommodation in employment, discrimination by association and positive action.

- *Decision on the European Year of People with Disabilities 2003* (2001/903/EC) - European Council (2001), a legislative act which states the establishment of the European Year dedicated to Disabilities
- *Communication on the implementation, results and overall assessment of the European Year of People with Disabilities 2003* COM (2005)486 - European Commission (2003), a non-binding act which reports on the impact of European Year initiatives

Statistic and data collection

The issue of statistics and data collection is crucial to the development of adequate monitoring policies and initiatives, in order to deepen results achieved and improvement areas.

European Union carries out several surveys that produce data on disability, directly or indirectly. However, only a handful of them are disability-specific.

The 2017 edition of Eurostat report “Sustainable development in the European Union: monitoring report on progress towards the SDGs in an EU context” follows the structure of the original Sustainable Development Goals, presenting disability under each Goal that mentions persons with disabilities. The report defines disability as a “limitation in activities people usually do because of health problems for at least the past six months”.

- *Regulation (EC) No 577/98 on the organization of a labor force sample survey in the Community* – European Council (1998), which provides Eurostat with yearly employment data from the Member States, including a specific focus on employment of disabled people, in particular health conditions and limitations, occupation, use of personal assistance and need for reasonable accommodation measures (last ad hoc survey was conducted in 2011, the results of which became available in 2014).
- *Regulation (EU) No 1157/2010 implementing Regulation (EC) No 1177/2003 of the European Parliament and of the Council concerning Community statistics on income and living conditions (EU-SILC)* – European Commission (2010), including questions on physical accessibility regarding basic needs, such as grocery, banking, postal services, healthcare and schooling for respondents with disabilities
- *Regulation (EC) No 1338/2008 on Community statistics on public health and health and safety at work* - European Parliament, European Council (2008), which covers, among other things, health status, chronic conditions, limitations in daily activities, physical and sensory functional limitations

- *Regulation (EU) No 99/2013 on the European statistical programme 2013-17* - European Parliament, European Council (2013), foresees to provide "statistics on key areas of social policy where the citizen is the center of interest". Disability is one of the key areas under this objective.

National legislation

In order to overcome discrimination of people with disabilities States should commit themselves with specific legal instruments transposing International and European regulation at National level.

An example is the Disability Discrimination Act, a set of laws aimed at reducing discrimination against people with disabilities. Several countries (Unites States (1990), Australia (1992), United Kingdom (1995), Hong Kong (1995), South Africa (2000), Pakistan (2002), Canada (2002)) enacted a Disability Discrimination Act, following the examples of laws promoting antidiscrimination and equal opportunities, aimed at preventing racial discrimination and sexism, at the end of 20th century/beginning of 21st century. A Discrimination Act is an important measure which allows us to better understand disability discrimination law, setting standards in the field of employment, architectural barriers, transportation, customer service and information and communications.

Recent reviews of national legislation concerning disability in Member States reveals that the situation is different from country to country. The European Association of Service providers for persons with disabilities released the 2017 Report with *10 Country Fact Sheets on "Social Care & Support Services Sector for Persons with Disabilities"*[3]. The aim of the fact sheets is to reflect the state of the art of the social care and support services sector for persons with disability, such as the type of services available for the different life-course stages, the nature of service providers in each of the indicated service subsectors; their target groups; their financing and governance; as well as any plans for substantial reform or regulation relating to this type of service delivery.

The 1st round of the research investigated the situation in Austria, Bulgaria, Finland, France, Ireland, Lithuania, Malta, Slovakia, Spain and the United Kingdom. In the future, EASPD plans to produce Fact sheets for other European countries. This research will provide very important materials in order to assess improvement areas.

Recommendations

Even though important improvements have been achieved from a legislative point of view, discrimination of people with disabilities remains a daily reality in Europe, ranging from visible forms to more subtle forms of social exclusion due to physical, psychological and social barriers.

Discrimination occurs in different situations, as the direct result of legislation or real facts, or as indirect consequence of measures that appear not to make any distinctions, but when applied to two people who live a different situation produce inequalities.

As the UN Convention on the Rights of Persons with Disabilities highlights, the active inclusion and full participation of disabled people in society can be achieved only through the contribution of several organizations and the development of multi-

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[3] Factsheets available at: http://www.easpd.eu/en/content/report-release-country-fact-sheets-social-care-support-services-sector-persons-disabilities

stakeholders' policies and action plans. For example, in order to ensure access to decent work to a person with mobility problems, this person needs to physically move in and out of his or her home, to access the public space and transportation, to access the work facilities (environment and information and communications systems).
Considering that people with disability have unique insights about their situation, their direct involvement in decision-making process is a crucial success factor.

Each organization should ensure that its specific sphere of responsibility provide the necessary opportunities and access to persons with disabilities, on an equal basis with others.
It's a network draw on international cooperation and local action, where if one knot fails in his obligation, persons are not able to benefit from improvements on other sides.

Recommendations at institutional level
The most complete and recent available reviews on legal instruments concerning the Union disabilities policies' report over two hundred legal instruments. These instruments cover a wide range of areas which are still affected by discrimination events. There are probably many other instruments, which are potentially relevant to persons with disabilities as to their content, but which do not include a reference to the Convention on the Rights of Persons with Disabilities or to the European Disability Strategy. For these reasons they are more difficult to identify and monitor.

As regards existing regulation, available information highlights some important aspects:

- European social policy already includes a strong disability dimension and recent instruments has raised the expectations for consistent disability mainstreaming as well of disability-specific instruments at both the EU and national levels;
- The development of the disability dimension in relation to accessibility of the internal market deserves special attention. Positive achievements (soft measures for accessibility, such as standardization, and the proposed equality directive which approaches accessibility from the anti-discrimination angle) are in contrast with other less disability-friendly initiatives;
- As regards transport policy, the legislative package is now complete, with four legislative instruments addressing passengers' rights in air, rail, maritime and road transport, but implementation difficulties are not solved yet, despite several guidance documents and publicity campaign;
- In fields such as education and health monitoring activity report a lack of instruments that could serve as a strong basis for developing CRPD-compliant practices;
- Horizontal instruments often refer to persons with disabilities with the concept of "*vulnerable*" users, consumers, or groups. Although the goal is to protect specific groups of people in specific situations, the over-use of the term "*vulnerable*" may undermine the notion of equality of persons with disabilities. Caution must be exercised when using the term and applying it to all persons with disabilities;
- According to CRPD Committee analysis, disability impact assessments should be reinforced as part of the fundamental rights impact assessment that is required for all new legislative initiatives, including a more comprehensive list of issues to better assess compliance with the Convention and defining a human rights-based

indicators system developed in cooperation with representative organizations of persons with disabilities;

- Eurostat should continue to develop a disability database and subsequent regular publication and disaggregated disability statistics and collaborate with national statistical agencies through the European Statistical System to harmonize the collection of disability data within the core EU surveys;
- It is essential to design and implement training addressed to the staff of the EU institutions involved in the law- and policy-making process on how to assess the impact of the EU policies on persons with disabilities.

Organizational level

If institutions are crucial in order to promote a non-discriminatory approach and a clear legal framework, as highlighted each organization has its own responsibility.

Each organization should carry out a thorough analysis of every aspect of its activity in order to ensure accessibility and inclusion.

In particular, all organizations have to mainstream disability in all activities. This check-list is an example of issues that an organization should consider:

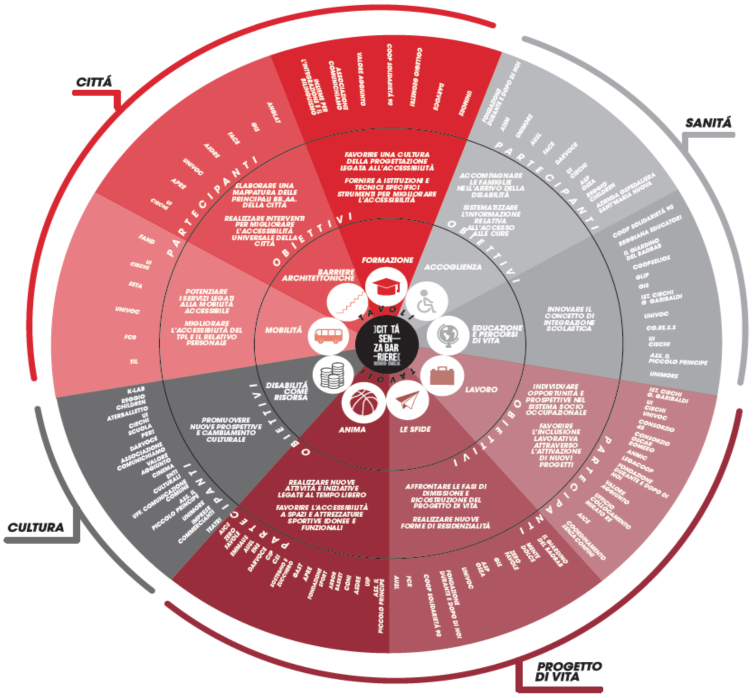
- *Mission and strategies*
  - Do we design our development projects and programmes to ensure that persons with disabilities can participate and benefit?
  - Do we collect data on the number of persons with disabilities which benefit from our development activities?
  - Do we require our partners/grantees to have policies and practices in place to ensure inclusion of persons with disabilities?

- *Human resources policies*
  - Do we have policies ensuring that the recruitment process is accessible to persons with different disabilities?
  - Do we have policies and resources which ensure that provision of *reasonable accommodation,* allowing persons with disabilities to work in our organization?
- *Facilities*
  - Are our buildings, office spaces, facilities accessible?
- *Information and Communication*
  - Is our website accessible?
  - Is sign language interpretation available?
  - Are documents available in Braille?

Good practice Title	**Reggio Emilia Città Senza Barriere**
Country	**Italy**
Type of practice	**Measure**
Included target groups	The project, started in 2017 thanks to the initiative of the Municipality of Reggio Emilia, is now developing thanks to the contribution of different organizations: • Organizations of persons with disability • Local institutions and local health services • Consortiums and social cooperatives • Umbrella organizations • Public and private employment services

	• Sport associations • Ngos and associations • Foundations • Theatre • Psychiatry Museum of Reggio Emilia • University TIL, Seta, FCR, Unione Italiana dei Ciechi, Unione Nazionale Volontari Pro Ciechi, FAND; ANGLAT, FACE, ASDRE, GIS, APRE, Insieme per l'integrazione e il bilinguismo, Associazione Comunichiamo, DarVoce, UNIMORE, Valore aggiunto, Collegio geometri, Coop Solidarietà 90, Unione Italiana dei Ciechi, AISM, Fondazione Dopo di Noi, DarVoce, Reggio Children, ASP OSEA, Azienda Ospedaliera S. Maria Nuova, AUSL, Coopselios, Ass. Il piccolo principe, Co.Re.s.s, UNIMORE, GLIP, Istituto ciechi “G. Garibaldi”, Reggiana educatori, Il giardino del baobab, Legacoop, AICE, Coordinamento Senza Confini, Consorzio Oscar Romero, ANMIC, Comitato dei genitori del servizio di consulenza tiflopedagogica “A. Romagnoli” Istituto “G. Garibaldi”, Consorzio 45, Ufficio Collocamento Mirato Provincia di Reggio Emilia, Zerofavole, Mente Dolce, AICS, ENS, ASDRE, CIP, GAST, ARBOR basket, Fondazione dello Sport, CSI, UIP, CONI, Il piccolo principe, Emmaus, Sostegno e zucchero, Danzability, GRD, Associazione Comunichiamo, Fondazione nazionale della danza, L'Indaco, Reggio Children, Associazioni Cinqueminuti, Let's dance, I Teatri, Cinema Rosebud, Corsiero editore, Musei civici, Peri, Associazione museo di storia della psichiatria, K-Lab
Requirements	• Multi-stakeholder action plan design • Cross-sector and cross-disability approach • Shared responsibility • Inclusion of persons with disabilities in all stages of implementation • Participatory process • Cultural approach
Description of practice	The project aims to overcome: • Architectural barriers, which hinder mobility and access; • Mental barriers, often the first cause of stigma and exclusion; • Relational barriers, which instintively bring to refuse and hide fragility. The project is structured in three macro-phases: need mapping, action development, monitoring and evaluation. **NEED MAPPING** For 18 months participants met in nine thematic groups: Transportation, Architectural barriers, Training, Hosting, Education and life path, Job, Challenges, Soul, Disability as a resource. Groups collected needs, requests and ideas and made a first feasibility assessment. Proposals were the result of a participatory process and included different points of view on disability and

	fragility. **ACTION DEVELOPMENT** The nine working groups selected 40 ideas and defined an action plan to develop them. The project promotes a shared responsibility and participants are directly involved in designing and implementing actions. They are not only requesting intervention from public authorities. They are building opportunities together with public authorities, no profit organizations, companies, etc., integrating several competences, resources and approaches. **MONITORING AND EVALUATION** Supported by FCR, working groups regularly monitor the development of actions and share results with local community, through meetings, events, press release, social networks, mailing lists.
Benefits for target group	• Capacity building process of all organizations involved • Awareness raising in local community
Source of funding	• Municipality of Reggio Emilia • Farmacie Comunali Riunite (subsidiary company of the Municipality) • Companies • No profit organizations • Volunteering activity



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CHAPTER 3: DISABILITIES AND THEIR IMPACT

WHO in its world report (2011) estimated ... "that more than a billion people live with some form of disability, or about 15% of the world's population (based on 2010 global population estimates). This is higher than previous World Health Organization estimates, which date from the 1970s and suggested around 10%. According to the World Health Survey around 785 million (15.6%) persons 15 years and older live with a disability, while the Global Burden of Disease estimates a figure of around 975 million (19.4%) persons. Of these, the World Health Survey estimates that 110 million people (2.2%) have very significant difficulties in functioning, while the Global Burden of Disease estimates that 190 million (3.8%) have "severe disability" – the equivalent of disability inferred for conditions such as quadriplegia, severe depression, or blindness. Only the Global Burden of Disease measures childhood disabilities (0–14 years), which is estimated to be 95 million (5.1%) children, of whom 13 million (0.7%) have "severe disability". The number of people with disabilities is therefore growing, reasons are that populations are ageing – older people have a higher risk of disability – and because of the global increase in chronic health conditions associated with disability, such as diabetes, cardiovascular diseases, and mental illness. Chronic diseases are estimated to account for 66.5% of all years lived with disability in low-income and middle-income countries".

Disability is complex, dynamic, multidimensional, and contested. Over recent decades, the disabled people's movement together with World report on disability numerous researchers from the social and health sciences – have identified the role of social and physical barriers in disability. The transition from an individual, medical perspective to a structural, social perspective has been described as the shift from a "medical model" to a "social model" in which people are viewed as being disabled by society rather than by their bodies.

The ICF, adopted as the conceptual framework for this World report on disability, understands functioning and disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental. Promoted as a "bio-psycho-social model", it represents a workable compromise between medical and social models. Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

The International Classification of Functioning, Disability and Health (ICF) advanced the understanding and measurement of disability. The ICF emphasizes environmental factors in creating disability, which is the main difference between this new classification and the previous International Classification of Impairments, Disabilities, and Handicaps (ICIDH). In the ICF, problems with human functioning are categorized in three interconnected areas:

- impairments are problems in body function or alterations in body structure – for example, paralysis or blindness;

- activity limitations are difficulties in executing activities – for example, walking or eating;

- participation restrictions are problems with involvement in any area of life – for example, facing discrimination in employment or transportation.

Disability refers to difficulties encountered in any or all three areas of functioning. The ICF can also be used to understand and measure the positive aspects of functioning such as body functions, activities, participation and environmental facilitation. The ICF adopts neutral language and does not distinguish between the type and cause of disability – for instance, between "physical" and "mental" health. "Health conditions" are diseases, injuries, and disorders, while "impairments" are specific decrements in body functions and structures, often identified as symptoms or signs of health conditions. Disability arises from the interaction of health conditions with contextual factors – environmental and personal factors as shown in the figure below. Representation of the International Classification of Functioning, Disability and Health condition (disorder or disease) Body functions and structures Activities Participation Environmental Factors Personal factors The ICF contains a classification of environmental factors describing the world in which people with different levels of functioning must live and act. These factors can be either facilitators or barriers. Environmental factors include products and technology; the natural and built environment; support and relationships; attitudes; and services, systems, and policies. The ICF also recognizes personal factors, such as motivation and self-esteem, which can influence how much a person participates in society.

UN Convention on the Rights of Persons with disabilities defines disability as an evolving concept – disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others (Preamble). Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

One of important questions is connected with stigma, defined as a deeply discrediting attribute that reduces a person to one who is in some way tainted and can therefore be denigrated. It is a pervasive problem that affects health globally, threatening an individual's psychological and physical well-being. It prevents individuals from coming forward for diagnosis and impairs their ability to access care or participate in research studies designed to find solutions. Stigmatization of certain diseases and conditions is a universal phenomenon that can be seen across all countries, societies and populations. It refers to the relation between "the differentness of an individual and the devaluation society places on that particular differentness". For stigmatization to be consistently effective, however, the stigmatized person must acquiesce to society's devaluation. When people with "differentness" internalize society's devaluation, they

do not feel empowered to change the situation and the negative stereotypes become an accepted part of their concept of the disorder. The labelling, stereotyping, separation from others and consequent loss of status highlight the role of power relations in the social construction of stigma.

1. Vision impairments

Key facts

- Globally, WHO estimated that approximately 1.3 billion people live with some form of vision impairment.
- With regards to distance vision, 188.5 million people have mild vision impairment, 217 million have moderate to severe vision impairment, and 36 million people are blind.
- With regards to near vision, 826 million people live with a near vision impairment.
- Globally, the leading causes of vision impairment are uncorrected refractive errors and cataracts.
- Approximately 80% of all vision impairment globally is considered avoidable.
- The majority of people with vision impairment are over the age of 50 years.

Definitions

The International Classification of Diseases 11 (2018) classifies vision impairment into two groups, distance and near presenting vision impairment.

Distance vision impairment:

- Mild – presenting visual acuity worse than 6/12
- Moderate – presenting visual acuity worse than 6/18
- Severe – presenting visual acuity worse than 6/60
- Blindness – presenting visual acuity worse than 3/60

Prevalence

Globally, it is estimated that approximately 1.3 billion people live with some form of distance or near vision impairment.

With regards to distance vision, 188.5 million have mild vision impairment, 217 million have moderate to severe vision impairment, and 36 million people are blind (1). With regards to near vision, 826 million people live with a near vision impairment (2).

Population growth and ageing will increase the risk that more people acquire vision impairment.

Causes

Globally, the leading causes of vision impairment are:

- uncorrected refractive errors
- cataract
- age-related macular degeneration
- glaucoma
- diabetic retinopathy
- corneal opacity
- trachoma.

There is some variation in the causes across countries. For example, the proportion of vision impairment attributable to cataract is higher in low- and middle-income countries than high-income countries. In high income countries, diseases such as diabetic retinopathy, glaucoma and age-related macular degeneration are more common.

Among children, the causes of vision impairment varies considerably across countries. For example, in low-income countries congenital cataract is a leading cause, whereas in high income countries it is more likely to be retinopathy of prematurity.

Strategies to address vision impairment

Approximately 80% of vision impairment globally is considered avoidable. There are effective interventions available to prevent and treat eye diseases. For example, uncorrected refractive error can be corrected with glasses while cataract surgery can restore vision. Vision rehabilitation is also effective in improving functioning for people with an irreversible vision impairment.

WHO response

WHO's work is guided by the publication *Universal eye health: a global action plan 2014-2019,* which was agreed to by a resolution at the World Health Assembly in 2013.

Over the last few years, WHO has developed and implemented several tools to support countries to assess the provision of eye care services:

- Eye care services assessment tool
- Tool for assessment of diabetes and diabetic retinopathy
- Tool for assessment of rehabilitation services and systems

WHO is also developing a *World report on vision*. The report will offer recommendations, including a number focused on ensuring comprehensive and integrated eye care in countries. It is expected the report will help to shape the global agenda on vision, including assisting Member States to reduce the burden of eye diseases, improve the lives of people with vision impairment and achieve the Sustainable Development Goals.

2. Hearing impairments

Key facts

- Around 466 million people worldwide have disabling hearing loss (1), and 34 million of these are children.
- It is estimated that by 2050 over 900 million people will have disabling hearing loss.
- Hearing loss may result from genetic causes, complications at birth, certain infectious diseases, chronic ear infections, the use of drugs, exposure to excessive noise, and ageing.
- 60% of childhood hearing loss is due to preventable causes.
- 1.1 billion young people (aged between 12–35 years) are at risk of hearing loss due to exposure to noise in recreational settings.
- Unaddressed hearing loss poses an annual global cost of US$ 750 billion. Interventions to prevent, identify and address hearing loss are cost-effective and can bring great benefit to individuals.
- People with hearing loss benefit from early identification; use of hearing aids, cochlear implants and other assistive devices; captioning and sign language; and other forms of educational and social support.

Over 5% of the world's population – or 466 million people – has disabling hearing loss (432 million adults and 34 million children). It is estimated that by 2050 over 900 million people – or one in every ten people – will have disabling hearing loss.

Disabling hearing loss refers to hearing loss greater than 40 decibels (dB) in the better hearing ear in adults and a hearing loss greater than 30 dB in the better hearing ear in children. The majority of people with disabling hearing loss live in low- and middle-income countries.

Approximately one third of people over 65 years of age are affected by disabling hearing loss. The prevalence in this age group is greatest in South Asia, Asia Pacific and sub-Saharan Africa.

A person who is not able to hear as well as someone with normal hearing – hearing thresholds of 25 dB or better in both ears – is said to have hearing loss. Hearing loss may be mild, moderate, severe, or profound. It can affect one ear or both ears and leads to difficulty in hearing conversational speech or loud sounds.

'Hard of hearing' refers to people with hearing loss ranging from mild to severe. People who are hard of hearing usually communicate through spoken language and can benefit from hearing aids, cochlear implants, and other assistive devices as well as captioning. People with more significant hearing losses may benefit from cochlear implants.

'Deaf' people mostly have profound hearing loss, which implies very little or no hearing. They often use sign language for communication.

Causes of hearing loss and deafness

The causes of hearing loss and deafness can be congenital or acquired.

Impact of hearing loss

Functional impact

One of the main impacts of hearing loss is on the individual’s ability to communicate with others. Spoken language development is often delayed in children with unaddressed hearing loss.

Unaddressed hearing loss and ear diseases such as otitis media can have a significantly adverse effect on the academic performance of children. They often have increased rates of grade failure and greater need for education assistance. Access to suitable accommodations is important for optimal learning experiences but are not always available.

Social and emotional impact

Exclusion from communication can have a significant impact on everyday life, causing feelings of loneliness, isolation, and frustration, particularly among older people with hearing loss.

Economic impact

WHO estimates that unaddressed hearing loss poses an annual global cost of US$ 750 billion. This includes health sector costs (excluding the cost of hearing devices), costs of educational support, loss of productivity, and societal costs.

In developing countries, children with hearing loss and deafness rarely receive any schooling. Adults with hearing loss also have a much higher unemployment rate. Among those who are employed, a higher percentage of people with hearing loss are in the lower grades of employment compared with the general workforce.

Improving access to education and vocational rehabilitation services and raising awareness especially among employers about the needs of people with hearing loss, will decrease unemployment rates for people with hearing loss.

Prevention

Overall, it is suggested that half of all cases of hearing loss can be prevented through public health measures.

Identification and management

Early detection and intervention are crucial to minimizing the impact of hearing loss on a child's development and educational achievements. In infants and young children with hearing loss, early identification and management through infant hearing screening programmes can improve the linguistic and educational outcomes for the child. Children with deafness should be given the opportunity to learn sign language along with their families.

Pre-school, school and occupational screening for ear diseases and hearing loss is an effective tool for early identification and management of hearing loss.

People with hearing loss can benefit from the use of hearing devices, such as hearing aids, cochlear implants, and other assistive devices. They may also benefit from speech therapy, aural rehabilitation and other related services. However, global production of hearing aids meets less than 10% of global need and less than 3% of developing countries' needs. The lack of availability of services for fitting and maintaining these devices, and the lack of batteries are also barriers in many low-income settings.

Making properly-fitted, affordable hearing aids and cochlear implants and providing accessible follow-up services in all parts of the world will benefit many people with hearing loss.

People who develop hearing loss can learn to communicate through development of lip-reading skills, use of written or printed text, and sign language. Teaching in sign language will benefit children with hearing loss, while provision of captioning and sign language interpretation on television will facilitate access to information.

Officially recognizing national sign languages and increasing the availability of sign language interpreters are important actions to improve access to sign language services. Encouraging organizations of people with hearing loss, parents and family support groups; and strengthening human rights legislation can also help ensure better inclusion for people with hearing loss.

3. Intellectual/Learning disabilities

WHO defines intellectual disability as a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development. Disability depends not only on a child's health conditions or impairments but also and crucially on the extent to which environmental factors support the child's full participation and inclusion in society. The use of the term intellectual disability in the context of the WHO initiative "Better health, better lives" includes children with autism who have intellectual impairments. It also encompasses children who have been placed in institutions because of perceived disabilities or family rejection and who consequently acquire developmental delays and psychological problems.

Mental and behavior disorders are condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.
Degrees of mental retardation are conventionally estimated by standardized intelligence tests. These can be supplemented by scales assessing social adaptation in a given environment. These measures provide an approximate indication of the degree of mental retardation. The diagnosis will also depend on the overall assessment of intellectual functioning by a skilled diagnostician.
Intellectual abilities and social adaptation may change over time, and, however poor, may improve as a result of training and rehabilitation. Diagnosis should be based on the current levels of functioning.

Intellectual/learning disabilities are usually classified into four categories:

- **Mild mental retardation**, where IQ range of 50 to 69 (in adults, mental age from 9 to under 12 years). Likely to result in some learning difficulties in school. Many adults will be able to work and maintain good social relationships and contribute to society.
- **Moderate mental retardation** where approximate IQ range of 35 to 49 (in adults, mental age from 6 to under 9 years). Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults will need varying degrees of support to live and work in the community.
- **Severe mental retardation** is defined as approximate IQ range of 20 to 34 (in adults, mental age from 3 to under 6 years). Likely to result in continuous need of support.
- **Profound mental retardation** defines IQ under 20 (in adults, mental age below 3 years). Results in severe limitation in self-care, continence, communication and mobility.

4. Physical/Mobility disabilities

Mobility impairment is defined as a category of disability that includes people with varying types of physical disabilities. This type of disability includes upper or lower limb loss or disability, manual Exterity and disability in co-ordination with different organs of the body. Disability in mobility can either be a congenital or acquired with age problem. This problem could also be the consequence of disease. People who have a broken skeletal structure also fall into this category of disability. Persons with physical impairment disabilities often use assistive devices or mobility aids such as wheelchairs and artificial limbs to obtain mobility.

The physical disability the person experiences may be either congenital, or a result of injury, muscular dystrophy, cerebral palsy, amputation, multiple sclerosis, pulmonary disease, heart disease or other reasons.

Physical and mobility impairment can be defined as a limitation in independent, purposeful physical movement of the body or of one or more extremities. According to this definition, the alteration in the person's mobility may be either temporary, or more permanent. Most of the diseases and rehabilitative states involved in physical and mobility impairments do involve a degree of immobility. These are often associated with things such as leg fractures, strokes, morbid obesity, trauma, and Multiple Sclerosis, for example.

Mobility is related to changes in a person's body as they age as well. Loss in muscle strength and mass, less mobile and stiffer joints, as well as gait changes affect a person's balance and may significantly comprise their mobility. Mobility is crucial to the maintenance of independent living among Seniors. If a person's mobility is restricted, it may affect their activities of daily living.

The characteristics of physical and mobility impairments involve many different things.

- Persons with physical and mobility impairments may experience deficits in motor and/or fine motor functioning, locomotor and non-locomotor functioning.
- There is the potential for deficits in cognitive, social, and adaptive behavior skills, as well as impairments in language, vision, hearing or other sensory areas.
- Persons with physical and mobility impairments may experience stiffness and/or spasticity, as well as loss of muscle strength. They may need help with learning, or activities of daily living.
- Persons with physical and mobility impairments may need assistance with mobility, transfers, and ambulation.

- They may have a limited range of motion, and be reluctant to attempt movement, or experience a perceptual or cognitive impairment.
- They may experience pain, discomfort; depression or anxiety.
- Persons with these impairments may require prolonged bed rest and have medical restrictions.
- They may have musculoskeletal or neuromuscular impairments as well.

5. Psychological and psychiatric conditions (mental health)

Key facts:

There are many different mental disorders, with different presentations. They are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behavior and relationships with others. Mental disorders include depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism. There are effective strategies for preventing mental disorders such as depression. There are effective treatments for mental disorders and ways to alleviate the suffering caused by them. Access to health care and social services capable of providing treatment and social support is key.

The burden of mental disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries of the world.

Depression

Depression is a common mental disorder and one of the main causes of disability worldwide. Globally, an estimated 300 million people are affected by depression. More women are affected than men.

Depression is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. People with depression may also have multiple physical complaints with no apparent physical cause. Depression can be long-lasting or recurrent, substantially impairing people’s ability to function at work or school and to cope with daily life. At its most severe, depression can lead to suicide.

Prevention programmes have been shown to reduce depression, both for children (e.g. through protection and psychological support following physical and sexual abuse) and adults (e.g. through psychosocial assistance after disasters and conflicts).

There are also effective treatments. Mild to moderate depression can be effectively treated with talking therapies, such as cognitive behavior therapy or psychotherapy. Antidepressants can be an effective form of treatment for moderate to severe depression but are not the first line of treatment for cases of mild depression. They should not be used for treating depression in children and are not the first line of treatment in adolescents, among whom they should be used with caution.

Management of depression should include psychosocial aspects, including identifying stress factors, such as financial problems, difficulties at work or physical or mental abuse, and sources of support, such as family members and friends. The maintenance or reactivation of social networks and social activities is important.

Bipolar affective disorder

This disorder affects about 60 million people worldwide. It typically consists of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated or irritable mood, over-activity, pressure of speech, inflated self-esteem and a decreased need for sleep. People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder.

Effective treatments are available for the treatment of the acute phase of bipolar disorder and the prevention of relapse. These are medicines that stabilize mood. Psychosocial support is an important component of treatment.

Schizophrenia and other psychoses

Schizophrenia is a severe mental disorder, affecting about 23 million people worldwide. Psychoses, including schizophrenia, are characterized by distortions in thinking, perception, emotions, language, sense of self and behavior. Common psychotic experiences include hallucinations (hearing, seeing or feeling things that are not there) and delusions (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary). The disorder can make it difficult for people affected to work or study normally.

Stigma and discrimination can result in a lack of access to health and social services. Furthermore, people with psychosis are at high risk of exposure to human rights violations, such as long-term confinement in institutions.

Schizophrenia typically begins in late adolescence or early adulthood. Treatment with medicines and psychosocial support is effective. With appropriate treatment and social support, affected people can lead a productive life, be integrated in society. Facilitation of assisted living, supported housing and supported employment can act as a base from which people with severe mental disorders, including Schizophrenia, can achieve numerous recovery goals as they often face difficulty in obtaining or retaining normal employment or housing opportunities.

Dementia

Worldwide, approximately 50 million people have dementia. Dementia is usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behavior, or motivation.

Dementia is caused by a variety of diseases and injuries that affect the brain, such as Alzheimer's disease or stroke.

Though there is no treatment currently available to cure dementia or to alter its progressive course, many treatments are in various stages of clinical trials. Much can be done, however, to support and improve the lives of people with dementia and their careers and families.

Developmental disorders, including autism

Developmental disorder is an umbrella term covering intellectual disability and pervasive developmental disorders including autism. Developmental disorders usually have a childhood onset but tend to persist into adulthood, causing impairment or delay in functions related to the central nervous system maturation. They generally follow a steady course rather than the periods of remissions and relapses that characterize many other mental disorders.

Intellectual disability is characterized by impairment of skills across multiple developmental area such as cognitive functioning and adaptive behavior. Lower intelligence diminishes the ability to adapt to the daily demands of life.

Symptoms of pervasive developmental disorders, such as autism, include impaired social behavior, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively. Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability.

Family involvement in care of people with developmental disorders is very important. Knowing what causes affected people both distress and wellbeing is an important element of care, as is finding out what environments are most conductive to better learning. Structure to daily routines help prevent unnecessary stress, with regular times for eating, playing, learning, being with others, and sleeping. Regular follow up by health services of both children and adults with developmental disorders, and their careers, needs to be in place.

The community at large has a role to play in respecting the rights and needs of people with disabilities.

Who is at risk from mental disorders?

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviors and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support.

Stress, genetics, nutrition, perinatal infections and exposure to environmental hazards are also contributing factors to mental disorders.

Health and support

Health systems have not yet adequately responded to the burden of mental disorders. Consequently, the gap between the need for treatment and its provision is wide all over the world. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder. In high-income countries, between 35% and 50% of people with mental disorders are in the same situation.

A further compounding problem is the poor quality of care for many of those who do receive treatment.

In addition to support from health-care services, people with mental illness require social support and care. They often need help in accessing educational programmes which fit their needs, and in finding employment and housing which enable them to live and be active in their local communities.

WHO response

WHO's Mental Health Action Plan 2013-2020, endorsed by the World Health Assembly in 2013, recognizes the essential role of mental health in achieving health for all people. The plan includes 4 major objectives:

- more effective leadership and governance for mental health;
- the provision of comprehensive, integrated mental health and social care services in community-based settings;
- the implementation of strategies for promotion and prevention; and
- strengthened information systems, evidence and research.

WHO's Mental Health Gap Action Programme (mhGAP), launched in 2008, uses evidence-based technical guidance, tools and training packages to expand service in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions, directing capacity building towards non-specialized health-care providers in an integrated approach that promotes mental health at all levels of care.

6. Autism spectrum disorders

Key facts

- 1 in 160 children has an autism spectrum disorder (ASD).
- ASDs begin in childhood and tend to persist into adolescence and adulthood.
- While some people with ASD can live independently, others have severe disabilities and require life-long care and support.

- Evidence-based psychosocial interventions, such as behavioral treatment and parent skills training programmes, can reduce difficulties in communication and social behavior, with a positive impact on wellbeing and quality of life for persons with ASD and their caregivers.
- Interventions for people with ASD need to be accompanied by broader actions for making physical, social and attitudinal environments more accessible, inclusive and supportive.
- Worldwide, people with ASD are often subject to stigma, discrimination and human rights violations. Globally, access to services and support for people with ASD is inadequate.

ASD refers to a range of conditions characterized by some degree of impaired social behavior, communication and language, and a narrow range of interests and activities that are both unique to the individual and carried out repetitively.

ASDs begin in childhood and tend to persist into adolescence and adulthood. In most cases the conditions are apparent during the first 5 years of life.

Individuals with ASD often present other co-occurring conditions, including epilepsy, depression, anxiety and attention deficit hyperactivity disorder (ADHD). The level of intellectual functioning in individuals with ASDs is extremely variable, extending from profound impairment to superior levels.

Epidemiology

It is estimated that worldwide 1 in 160 children has an ASD. This estimate represents an average figure, and reported prevalence varies substantially across studies. Some well-controlled studies have, however, reported figures that are substantially higher. The prevalence of ASD in many low- and middle-income countries is so far unknown.

Based on epidemiological studies conducted over the past 50 years, the prevalence of ASD appears to be increasing globally. There are many possible explanations for this apparent increase, including improved awareness, expansion of diagnostic criteria, better diagnostic tools and improved reporting.

Causes

Available scientific evidence suggests that there are probably many factors that make a child more likely to have an ASD, including environmental and genetic factors.

Available epidemiological data are conclusive that there is no evidence of a causal association between measles, mumps and rubella vaccine, and ASD. Previous studies suggesting a causal link were found to be filled with methodological flaws.

There is also no evidence to suggest that any other childhood vaccine may increase the risk of ASD. Evidence reviews of the potential association between thiomersal preservative and aluminum adjuvants contained in inactivated vaccines and the risk of ASD strongly concluded that vaccines do not increase the risk of ASDs.

Assessment and management

Intervention during early childhood is important to promote the optimal development and well-being of people with an ASD. Monitoring of child development as part of routine maternal and child health care is recommended.

It is important that, once identified, children with an ASD and their families are offered relevant information, services, referrals, and practical support according to their individual needs. A cure for ASD is not available. Evidence-based psychosocial interventions, however, such as behavioral treatment and skills training programmes for parents and other caregivers, can reduce difficulties in communication and social behavior, with a positive impact on the person's wellbeing and quality of life.

The health-care needs of people with ASD are complex and require a range of integrated services, including health promotion, care, rehabilitation services, and collaboration with other sectors such as the education, employment and social sectors.

Interventions for people with ASD and other developmental disorders need to be accompanied by broader actions for making their physical, social, and attitudinal environments more accessible, inclusive and supportive.

Social and economic impacts

ASDs may significantly limit the capacity of an individual to conduct daily activities and participate in society. ASD often negatively influence the person's educational and social attainments as well as employment opportunities.

While some individuals with ASD can live independently, others have severe disabilities and require life-long care and support.

ASDs often impose significant emotional and economic burden on people with these disorders and their families. Caring for children with the severe spectrum of the condition may be demanding, especially where access to services and support are inadequate. Therefore, the empowerment of caregivers is increasingly being recognized as a critical component of care interventions for children with ASD.

Human rights

People with ASD are often subject to stigma and discrimination, including unjust deprivation of health, education and opportunities to engage and participate in their communities.

People with ASD have the same health problems that affect the general population. Furthermore, they may have specific health care needs related to ASD or other co-occurring conditions. They may be more vulnerable to developing chronic noncommunicable conditions because of behavioral risk factors such as physical inactivity and poor dietary preferences, and are at greater risk of violence, injury and abuse.

People with ASD require accessible health services for general health-care needs like the rest of the population, including promotive and preventive services and treatment of acute and chronic illness. Nevertheless, people with ASD have higher rates of unmet health-care needs compared with the general population. They are also more vulnerable during humanitarian emergencies. A common barrier is created by health-care providers' inadequate knowledge of ASD and misconceptions.

WHO Resolution on autism spectrum disorders

In May 2014, the Sixty-seventh World Health Assembly adopted a resolution entitled *"Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASD),"* which was supported by more than 60 countries. The resolution urges WHO to collaborate with Member States and partner agencies to strengthen national capacities to address ASD and other developmental disorders.

Efforts are focusing on:

- contributing to enhancing commitment of governments and international advocacy on autism;
- providing guidance on creating policies and action plans that address ASD within the broader framework of mental health and disabilities;
- contributing to the development of evidence on effective and scalable strategies for the assessment and treatment of ASD and other developmental disorders.

7. Neurological conditions

There is ample evidence that pinpoints neurological disorders as one of the greatest threats to public health. Several gaps exist in understanding the many issues related to neurological disorders, but we already know enough about their nature and treatment to be able to shape effective policy responses to some of the most prevalent among them: common neurological disorders such as dementia, epilepsy, headache disorders, multiple sclerosis, neuroinfectious, neurological disorders associated with malnutrition, pain associated with neurological disorders, Parkinson's disease, stroke and traumatic brain injuries.

Many neurological disorders and conditions affect an individual's functioning and result in disabilities or limit activities and restrict participation. According to the International Classification of Functioning, Disability and Health (ICF), the medical model views disability as a problem of the person, directly caused by disease, trauma or other health condition that requires medical care provided in the form of individual treatment by professionals. Management of the disability is aimed at cure or the individual's adjustment and behavior change. The social model of disability sees the issue mainly as a socially created problem and a matter related to the full integration of individuals into society. According to the social model, disability is not an attribute of the individual, but rather a complex collection of conditions, many of which are created by the social environment: the approach to disability requires social action and is a responsibility of society. Rehabilitation WHO defined rehabilitation as an active process by which those affected by injury or disease achieve a full recovery or, if a full recovery is not possible, realize their optimal physical, mental and social potential and are integrated into their most appropriate environment. Rehabilitation is one of the key components of the primary health-care strategy, along with promotion, prevention and treatment. While promotion and prevention primarily target risk factors of disease and public health principles and neurological disorders treatment targets ill-health, rehabilitation targets human functioning. As with other key health strategies, it is of varying importance and is relevant to all other medical specialties and health professions. Though rooted in the health sector, rehabilitation is also relevant to other sectors including education, labor and social affairs. For example, building of ramps and other facilities to improve access by disabled people falls beyond the purview of the health sector but is nevertheless very important for the comprehensive management of a person with a disability. As a health-care strategy, rehabilitation aims to enable people who experience or are at risk of disability to achieve optimal functioning, autonomy and self-determination in the interaction with the larger physical, social and economic environment. It is based on the integrative model of human functioning, disability and health, which understands human functioning and disability both as an experience in relation to health conditions and impairments and as a result of interaction with the environment. Rehabilitation involves a coordinated and iterative problem-solving process along the continuum of care from the acute hospital to the community. It is based on four key approaches integrating a wide spectrum of interventions:

1) biomedical and engineering approaches;

2) approaches that build on and strengthen the resources of the person;

3) approaches that provide for a facilitating environment; and

4) approaches that provide guidance across services, sectors and payers.

Specific rehabilitation interventions include those related to physical medicine, pharmacology and nutrition, psychology and behavior, education and counselling, occupational and vocational advice, social and supportive services, architecture and engineering and other interventions. Rehabilitation services are like a bridge between isolation and exclusion — often the first step towards achieving fundamental rights. Health is a fundamental right, and rehabilitation is a powerful tool to provide personal empowerment.

Rehabilitation should start as soon as possible after the diagnosis of a neurological disorder or condition and should focus on the community rehabilitation perspective. The type and provision of services is largely dependent on the individual health-care system. Therefore, no generally agreed principles currently exist regarding the provision of rehabilitation and related services.

There are several complexities in the process of neurorehabilitation, as patients can present with diverse sequelae, including the following:

- Physical functioning limitations can be evident in many ways — such as paralysis of the left or right side of the body, or both sides — which limit severely the person's capacity for many daily living activities, as well as mobility in the community and, eventually, the capacity to return to work or school. Patients can also present with rigidity, uncoordinated movements, and/or weakness. In developing countries, people with disabilities have very limited access not only to rehabilitation services but also to appropriate assistive technology, such as adequate wheelchairs: persons with head injury who require wheelchairs for adequate positioning and mobility may be severely impaired in their possibility to leave their house and participate in community activities, access educational facilities, or work.
- Cognitive impairments can manifest in the form of memory and attention problems, mild to severe intellectual deficiency, lack of perseverance and a limited ability to learn, all of which can make it impossible to return to work, may affect emotional stability, and limit performance at work or at home. All these problems will affect the person's emotional status, as well as that of the family and friends. It can also mean social isolation in the long term, aggravating depression.
- Behavioral problems such as poor impulse control, uncontrolled anger and sexual impulses, lack of insight and perseverance, and the impossibility to learn from past errors are only some of the behavioral sequelae that affect the person's capacity to get involved and be accepted socially, and further limit the possibility of returning to educational or vocational services. Behavioral problems can also become evident when the person affected realizes the severity of his or her limitations, and the fact that they may be permanent.
- Communication impairments in the form of speech problems, poor vocalization or stomas, in combination with lack of access to augmentative or alternative communication devices in developing countries.
- Basic daily living activities are affected by functional and cognitive limitations.
- Psychosocial limitations, such as limited access to education, the impossibility to return to vocational status or be relocated vocationally, are consequences of previously mentioned limitations, all of which further impact on the behavioral, physical and cognitive aspects of the person affected by a neurological disorder that causes disability.

8. Brain injury

Traumatic brain injury is the leading cause of death and disability in children and young adults around the world and is involved in nearly half of all trauma deaths. Many years of productive life are lost, and many people have to suffer years of disability after brain injury. In addition, it engenders great economic costs for individuals, families and society. Many lives can be saved, and years of disability spared through better prevention.

Traumatic brain injury (TBI), a form of acquired brain injury, can result when the head suddenly and violently hits, or is hit by, an object or when an object pierces the skull and enters brain tissue; the latter are called “open” injuries. TBI may result from motor vehicle accidents, sports accidents, falls, assaults (including child abuse), or gunshot wounds. TBI does not include injuries resulting from a tumor, stroke, primary hypoxia, degenerative disease, etc.

If the head is hit by an external mechanical force, the brain will be displaced inside the skull and can be injured against the solid meningeal membrane, the dura, or against the inside of the neurocranium. Acceleration and deceleration forces may disrupt the nervous tissue and blood vessels of the brain. All grades of injury can occur, ranging from no visible abnormality of the brain in cases of mild TBI to superficial bruising (contusion), and, in severe cases, dramatic swelling (edema) as well as large collections of blood (hematomas). Initial classification of TBI is based mostly upon the clinical examination which is carried out by the physician in the hospital’s accident and emergency department. Around 90% of TBIs are classified as “mild”, implying that the patient is awake but may have had a loss of consciousness and/or a short amnesia. Only 3–5% are “severe” TBIs, meaning that the patient is unconscious upon admission.

TBI is often classified as mild, moderate or severe, based on assessments at the time of presentation and during acute recovery over the first few weeks following the injury.

Incidence In Tagliaferri’s European study, the TBI incidence rate collected from 23 reports with epidemiological data was found to vary greatly between countries. Some of the differences could be ascribed to variations in study years, inclusion criteria and research methods. Most rates were in the range 150–300 per 100 000 population per year. The estimated European incidence of TBI was 235 per 100 000 per year, including all hospitalized patients with head injury and those dying of a head injury prior to admission. Admission policies, particularly in cases of mild TBI, will, of course, influence the incidence rates markedly. Therefore, incidence rates such as 546 per 100 000 per year in Sweden and 91 per 100 000 per year in Spain must be interpreted with caution. Data from many parts of the world consistently show a peak incidence rate in children, young adults and elderly people. Males are injured 2–3 times as often as women.
Prevalence of TBI measures the total number of injuries at a point in time or in a period interval; the calculation should include all those with TBI sequelae such as impairments, disabilities, handicaps or complaints, plus all the newly diagnosed cases at the defined time or time interval. Estimates from the United States indicate that 1–2% of the population, i.e. around five million people, live with a TBI disability. Many disabled people have neurobehavioral problems. It is therefore no exaggeration to describe TBI disability as an enormous public health problem. Information on how sequelae develop (diminish or increase) over time is scarce; better data on prevalence would certainly be useful for improved planning of rehabilitation needs.

Sources:

WHO (2001) International Classification of Functioning, Disability and Health, Geneva

WHO (2011) World Report on Disability https://www.who.int/disabilities/world_report/2011/en/

WHO (1992) International Statistical Classification of Diseases and Related Health Problems Tenth Revision, Geneva

United Nations Convention on the Rights of Persons with Disabilities https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

WHO Blindness and visual impairment at: https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment

WHO Deafness and hearing loss at: https://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss

WHO Autism Spectrum Disorders at: https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

Traumatic brain injury at: https://www.medicalhomeportal.org/diagnoses-and-conditions/traumatic-brain-injury

WHO Mental health at: https://www.who.int/mental_health/management/en/

Neurological Disorders Public Health Challenges at: https://www.who.int/mental_health/neurology/introduction_neuro_disorders_public_h_challenges.pdf?ua=1

Disabled World towards tomorrow at: https://www.disabled-world.com/disability/types/mobility/

Inclusive activities make use of diversity

According to the ***National Agency for Special Needs Education and Schools, SPSM,***
working with inclusion in activities for people with disabilities means utilizing the diversity and differences that exist within the organization by ensuring equal value for everyone and the right to an equal education with respect for the individual. What factors and abilities are required in the organization of the business and how successful it is, can be called the inclusion capacity of the organization. In order to drive the democratic process further, insight is needed on how their own activities work for children and pupils. This requires that the organization develops available learning environments and has a promotion work on the participation of children and pupils.

How to promote accessible learning environments

In a research article from 2018, a research group led by D Koller presents several international research on children and pupils with disabilities and social inclusion. The research review is written by researchers from Toronto, Canada. The article deals with children with disabilities and their opportunities for social inclusion in the home, in society and in school. In this summary, we highlight the results that are about the group's social inclusion in the school. Below is a summary of their findings.

Accessibility means that the Learning provider develops knowledge about the conditions for learning and how it is related to the educational, social and physical environments of the activity. In this work is to identify and eliminate obstacles and actively work to develop and improve the entire organizations learning environment, with a focus on environmental factors. The organizations ability to create accessible learning environments affects the opportunities for children and pupils to participate in both their learning and in the social community. The availability of learning environments is also a prerequisite for being able to develop inclusive activities.

Source:

- *Koller, D., Le Pouseard, M. & Rummens, J.A. (2018) Defining Social Inclusion for Children with Disabilities: A Critical Literature Review. Children & Society Volume 32, (2018) pp.1-13*
- https://www.spsm.se

Social inclusion

Social inclusion can not only be measured in the participation and acceptance of a marginalized group, in a specific social context. Consideration must also be given to how individuals control and perceive their own opportunity for participation. In the article, the authors make clear that they have not found any research that has specifically investigated how children and pupils with disabilities themselves perceive social inclusion. There are also few studies on how children and pupils, in general, perceive social inclusion and disability. For inclusive education, there are a number of practical applications, but very little information is available about applications in specific contexts. For this reason, the authors argue that the interventions that are carried out rarely relate to how children and students with disabilities perceive their social environment in the classroom. There is also no knowledge of how welcome they feel in their school or daily activities, how many friends they have or what quality is in their participation around decisions.

Source:

- *Koller, D., Le Pouseard, M. & Rummens, J.A. (2018) Defining Social Inclusion for Children with Disabilities: A Critical Literature Review. Children & Society Volume 32, (2018) pp.1-13*
- https://www.spsm.se

Barriers to social inclusion

Studies on children and students with disabilities show that they must overcome clear social, economic and political obstacles to achieve a sense of meaningful participation in society. The obstacles to social inclusion exist in all arenas of society. As far as the learning provider is concerned, this may be an obstacle to:

- access to inclusive activities in group situations.
- could develop relationships with their peers.
- Engage in play and social activities.

Social inclusion is a starting point for well-being and is a crucial aspect of the issue of developing a sense of value and an experience of being able to contribute to a social community. Children with disabilities are at increased risk of being isolated or bullied in comparison with children without disabilities. -Structured activities such as games where social inclusion is part of the play structure give a higher degree of social inclusion.

Source: Koller, D., Le Pouseard, M. & Rummens, J.A. (2018) Defining Social Inclusion for Children with Disabilities: A Critical Literature Review. Children & Society Volume 32, (2018) pp.1-13

https://www.spsm.se

A. Realistic adaptations

Realistic adaptations of social inclusion for people with disabilities are open communication between staff and guardians.

Inclusive training methodologies

The role of the teacher/trainer

The teacher/trainers should, with various pedagogical methods, compensate for the pupils' difficulties. They should ask themselves: are my instructions clear, there is a clear structure over the day, how does the transition between topics work?

Special teachers Christina Franzon Wallin and Josephine Andersson from Sigtuna writes in an article that pupils with disabilities perceive that the teacher has an important role in creating social inclusion in the teaching environment. It is because the teacher's attitude with regard to disability has a major impact on how inclusion in the environment works. It can have negative consequences both if the teacher has a negative attitude and if the teacher is overprotective. How a teacher chooses to act can also have consequences for how other students choose to meet and include students with disabilities. The attitude of the teacher/trainer to social inclusion is dependent on how long the teacher has experience in teaching participants with disabilities.
Teachers/Trainers need adequate training that provides positive attitudes about the social inclusion of learners with disabilities and, which promotes a sense of effectiveness. Positive attitude, resources for physical adaptation and pedagogical support structures are necessary to promote good experiences of inclusion in the classroom. In practice, it is often the resources that the organization has, rather than a teacher's attitude, which ultimately affects the form of learning environment and teaching.

Christina Franzon Wallin and Josephine Andersson have some recommended adaptions in the magazine: Specialpedagogik.se. They are:

- Written lesson instruction
- Well thought out furniture and location
- Operating Breaks
- Fewer tasks
- Clear feedback during work
- Help choosing another activity during the break

Source: https://specialpedagogik.se/extra-anpassningar-va-da-da/

Recommended adaptations for creative workshops

Following is some recommendations for trainers who want to organize creative workshops for persons with different disabilities.

General preparation

- Make sure it looks clean and tidy.
- Obtain all necessary equipment for the course.
- Prepare nameplates.
- Are there aprons?
- Keep an eye on how many people are coming and who they are, do we need to assist someone in the room; impaired vision, disability, etc.

Workshop Preparation

- You may need to arrange the working material in advance
- Remember: Participants in the target group have different levels of disabilities (visual impairment, low intellectual level, etc.)
- All exercises must be adaptable to different levels and disabilities

Introduction

- Hello everyone, welcome and show where they can hang out
- Show where the relaxation room is ("You can go and rest here if you want to"). It is important that there is a room for taking a break.
- Ask everyone to wear aprons that protect clothing
- Help everyone to find a place to work.
- Say hi and let everyone say their name (left to right).

Course leaders say:

- Hello and warmly welcome to today's workshop!
- My name is…
- I'm very happy that you all are here! (It is important that everyone feels welcome.)
- Introduce the topic of the day "Today we have a course / workshop topic".
- Inform the length of the workshop. "We will be here for x number of hours. We finish at x. We have a coffee break at x, for 15 minutes."
- Ask participants if they have arranged a way to get home after the activity.

"Do you know how to get home after the course? Taxi?"

- Inform about the location of the toilets.

"Toilets are located down the corridor to the right. Disability toilet available ...?" (The leader can accompany the participant to the bathroom to show were it is.)

- "We have a restroom that has a sofa and armchair. It's up to you if you need to go back for a while or want to lie down."

Course Introduction

The course leader explains briefly what the lesson of the day is about.

- One thing at a time, keep it simple, keep it short.
- Do not give too much information at once.
- Show an example of how it can look when it is done.

Warm up exercises / Ice breaker

Run any warm-up exercise for about 5-10 minutes.

During the workshop:

- The leader should encourage the participants with positive feedback, to take many breaks and to offer refreshments.

At the end of the class

When the lesson has 30 min left, we say:

"Now it's half an hour left and in ten minutes we'll finish and have a joint review for 20 minutes." Also remind them when it is 5 minutes and 1 min left for review.

Review:

Everyone signs their piece and we helped the participants to put the pieces on the wall.

We sit on chairs in a semi-circle in front of their work/pieces.

Ask everyone the same questions (left to right) and make sure everyone gets about the same amount of time. Examples of questions:

- Tell us what you have done today?
- What do you see when you look at your work?
- What have you learned today?
- How did you learn it?

Other questions:

- How was it coming here today?
- What did you think was the best?
- What was hard?
- What can we do to improve it?

Finishing:

Allow participants to help clean up about 15 minutes before the end of the course. If necessary, show how to wash brushes and other things.

Other:

- Encourage participants to enroll in more courses.
- It is good to encourage the participants to register with the organizer.

Source: Anders Romare, teacher at Medborgarskolan, coach with special training in working with people with disability and an artist

B Unbridgeable obstacles

Grave impairments due to congenital or acquired disease such as paralysis, Alzheimer's disease, schizophrenia, severe depression, autism, etc. are insurmountable obstacles for students to participate in an educational or social activity based on active participation.

C Demarcations

In order to be able to carry out an art workshop for a group of people with disabilities, the following limitations need to be made.

- You cannot have participants suffering from severe mental illness requiring careers with specialist expertise in place.
- You cannot have participants who require an interpreter or special educational aids if the participant does not have an assistant themselves.
- You cannot have participants with severe disability that they require individual teaching

- You cannot have participants who cannot participate in group activities due to social disabilities
- You can only have participants who can benefit from teacher-led teaching

Source: Anders Romare, teacher at Medborgarskolan, coach with special training in working with people with disability and an artist

D How to determine which demarcations to have

In the selection process it is important to determine which learners can be approved of allocation to be able to create a learning environment that is positive and will give the expected results.

Already at the planning stage, one should determine which criteria one has for the workshop's implementation, such as target group, educational resources, group size. In order to carry out a successful workshop, one should strive to have participants who are at about the same level regarding the ability to participate in the exercise and to take advantage of the teaching. One can thus have different groups that are at different levels.

Source: Anders Romare, teacher at Medborgarskolan, coach with special training in working with people with disability and an artist

2. Different types of adaptations to different physical impairments

Physical impairments - vision, hearing and disability in mobility

Deaf or impaired hearing

Not hearing or having any form of hearing loss can have different causes and be of different degrees. A person may have been diagnosed early or late and the hearing loss may occur on one or both ears, the impaired hearing can be innate or acquired. With all of these different kinds of impaired hearings the learning environment must be based on the individual's individual circumstances.

Not being able to hear is not visible but is noticed when communication takes place. Today, cochlear implants (CI) are operated on most people who have been told early on, of hearing loss. In case of easier hearing loss, the children can get a hearing aid. Many of these children also have benefit of sign language. Sign language works for everyone, not just for those who have hearing loss or are deaf, but also for those who don’t have an impaired hearing.

In a teaching context with people who are deaf or have a hearing loss, special requirements are placed in the learning environment and an example of that is a good visual environment, a good sound environment, knowledge of pedagogical strategies and use of learning tools. An important part of learning is the choice of communication.

Source: The National Agency for Special Needs Education and Schools, SPSM, Sweden, https://www.spsm.se/funktionsnedsattningar/dov-eller-nedsatt-horsel/

Australian Network on Disability, Australia

https://www.and.org.au/pages/examples.html

Visual impairment

A visual impairment involves difficulties in reading printed text, even with glasses and good lighting, or moving and orientate yourself with the help of eyesight.

Blindness is a visual defect that involves total lack of vision. There are aids in the form of, for example, Braille, guide dogs and white canes.

An important basis for all learning is to mimic and imitate. In case of visual impairment, this possibility is made difficult. Visual interpretation means, for example, that the teachers and the peers describe and name things and pay attention to phenomena in the outside world. In unknown environments, it may be particularly important to people with visual impairment to have a visual interpreter.

Customized teaching materials and an accessible learning environment are just some of the things that can support a person with visual impairment. The fact that educators and peers are aware of the disability is also a support.

Source: The National Agency for Special Needs Education and Schools, SPSM, Sweden,

https://www.spsm.se/funktionsnedsattningar/synnedsattning/

Australian Network on Disability, Australia

https://www.and.org.au/pages/examples.html

Deaf blindness, combined vision- and hearing loss

By seeing and hearing we understand our surroundings. If someone has both visual and hearing impairments the ability to interpret and understand what is happening around us decreases. The people who have a severe impairment in both vision and hearing belong to the group deafblindness.

There are many different causes to deafblindness. When in life deafblindness has arisen determines how the support needs to be. The question needs to be about whether if the deafblindness was from birth or if vision- and hearing deteriorated gradually or suddenly during the upbringing. In order to achieve a good quality of interaction and communication, adaptations are required. Individual educational adaptations of learning environments are particularly important.

In deafblind interpreting, various interpreting methods are used depending on the communication method preferred by the person with deafblindness. Some typical interpreting methods are tactile interpreting (tactile sign language), close vision interpreting (visual sign language within very close proximity to the person in question), visual frame interpreting (visual sign language to more than one person with deafblindness), clear speech interpreting (with or without hearing aids), finger spelling of the manual alphabet, and speech-to-text interpreting (with or without technical equipment such as a computers, large screens and Braille displays).

Source: The National Agency for Special Needs Education and Schools, SPSM, Sweden, https://www.spsm.se/funktionsnedsattningar/syn--och-horselnedsattning-eller-dovblindhet/

Australian Network on Disability, Australia

https://www.and.org.au/pages/examples.html

Mobility impairment

Disability in mobility is a collective term for several diagnoses. The diagnoses may be congenital or have been caused by injury or illness. Examples of mobility impairment are CP (cerebral palsy), spinal cord hernia, muscle diseases, rheumatism, unusual diagnoses and obtained brain injury.

Having mobility impairment can affect cognition, perception, communication and gross and fine motor skills. Combination with other disabilities may also occur, such as visual impairment, hearing loss and developmental disorder.

Students with physical disabilities may benefit from a range of inclusive teaching and assessment strategies. Some adjustments that are frequently used for people with physical disabilities in a learning environment include access to venues, for example ramps where there are stairs, space provided in teaching rooms to accommodate student's own furniture or adapted equipment and option to stand in classes or take short breaks to accommodate musculoskeletal issues. It also includes provision of modified equipment such as computers, access to text-to-speech software where writing or typing is impacted by the physical disability and provision of a separate room if speech recognition software is to be used. It's also important with breaks for resting.

Source: The National Agency for Special Needs Education and Schools, SPSM, Sweden, https://www.spsm.se/funktionsnedsattningar/rorelsehinder/

Australian Disability Clearinghouse on Education and Training, ADCET, Australia,

https://www.adcet.edu.au/students-with-disability/reasonable-adjustments-disability-specific/physical-disability/

Ferris State University, Michigan, USA

https://www.ferris.edu/htmls/colleges/university/disability/faculty-staff/classroom-issues/mobility/mobility-strategy.htm

Australian Network on Disability, Australia

https://www.and.org.au/pages/examples.html

3. Neuropsychiatric disabilities

Students with physical disabilities may benefit from a range of inclusive teaching and assessment strategies. Some adjustments that are frequently used for students with physical disabilities include access to venues, for example ramps where there are stairs, space provided in teaching rooms to accommodate student's own furniture or adapted equipment and option to stand in classes or take short breaks to accommodate musculoskeletal issues. It also includes provision of modified equipment, including computers, access to text-to-speech software where writing or typing is impacted by the physical disability, provision of a separate room if speech recognition software is to be used and rest breaks.

Neuropsychiatric disabilities (NPF) depend on how the brain works and works. The most common disabilities are ADHD, ASD / Asperger's syndrome, Tourette's syndrome and language disorder. The various diagnoses are closely related, and it is common for the same person to have several diagnoses. There is also high so-called co-morbidity, comorbidities, disorders and syndromes such as bipolar syndrome, anxiety disorder and depression.

Symptoms of NPF

We can all forget an appointment at a special time and have a hard time concentrating sometimes. It is only when the difficulties are so great that they greatly affect the individual's development and opportunities to function in society as it is about a disability. People with NPF often have difficulties with:

NPF often has difficulties with:

- regulation of attention

- impulse control and activity level

- the interaction with other people
- learning and memory
- to express themselves in speech and writing
- motor skills

Causes of NPF

Heredity
Research suggests that there is a hereditary tendency to develop neuropsychiatric problems. There are some factors that increase the likelihood of NPF. Common risk factors are stress during pregnancy, complications during childbirth and premature birth. Nutritional deficiency in the placenta or early meningitis are also risk factors. However, most children who have been exposed to any risk factor develop completely normally. There are also diseases whose symptoms, in rare cases, may meet the criteria for a neuropsychiatric disability. This applies to certain chromosomal abnormalities, epilepsy and some metabolic disorders.

Environmental impact
Poor growth environment cannot cause neuropsychiatric disabilities. However, an unfavorable environment can exacerbate the problems. It also works the other way around. A good environment with understanding relatives, friends, teachers, managers and co-workers, facilitates and reduces the symptoms and makes it easier to live with the disability.

Living with NPF

Small children

Neuropsychiatric disabilities often occur during childhood. Sometimes the problems are clearly noticeable in the early years, sometimes they are milder difficulties that are only expressed in certain situations. An early sign may be that the child does not learn to speak within the expected time. Many children with neuropsychiatric disabilities are significantly over-active. They find it unusually hard to sit still, jump from one activity to another and easily get into conflicts with other children. They can also be too passive and dreamy.
They may have difficulty adapting to a group and difficult to understand how to play.

Some children can get violent outbreaks without the environment understanding why and some children are motor-clumsy.

School children

The school demands that it be able to adapt and adhere to explicit and unspoken rules. Therefore, neuropsychiatric problems are often visible in connection with school start. It is easy for the children to be misunderstood as annoying and it is common for them to end up in conflict with their classmates. Many of the children also have learning difficulties. It can be reading and writing problems, difficulties in understanding or difficulty concentrating.

Teenagers

Young people with neuropsychiatric disabilities often ends up outside the social community. The impulsive ones easily end up in inappropriate companionships and the introverts often become lonely, unless they can maintain friendly relationships through their interests. Many have poor self-confidence, and some suffer from depression. Therefore, it is very important with support, guidance and present adults during adolescence.

Adults

When adolescence is over, many experience an improvement provided they have received the right help and support. NPF does not go away, but through maturity and life experience, many learn to compensate for their disability. Surveys that follow up on adults with neuropsychiatric disabilities unfortunately show that many are on sick leave or have permanent sickness compensation due to stress sensitivity and fatigue syndrome.

Source:
** text from Riksförbundet Attention*

(The National Association of Attention is an interest organization for people with neuropsychiatric disabilities (NPF) such as ADHD, Asperger's syndrome / Autism spectrum condition (AST), language disorder and Tourette's syndrome.)

4. Intellectual disability - developmental disorder

Having an intellectual disability or developmental disorder, acquired brain damage affects cognitive functions such as memory and abstract thinking. This has major consequences for the person's everyday life.

The intellectual ability varies in the population. Within the group of people with intellectual disabilities, the variation is even greater. The spread of intellectual ability in the population can be described as following a curve. The worse the intellectual ability - the fewer people are in the group. It is the same in the other direction. The greater the intellectual ability - the fewer people are also in that group. About one percent of the population in Sweden has an intellectual ability that is so low that it

becomes a disability.
There are two different diagnostic systems:

- ICD-10, International Classification of Diseases, published by the World Health Organization, WHO,
- DSM-5, Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association of American Psychiatric Association.

Both are systems for statistical classification with diagnostic codes to group diseases. There are several differences between the two systems. For example, the concept of intellectual disability in DSM 5 and developmental disorder in the Swedish translation of ICD 10 are used. There are also differences in the autism area. Intellectual disability and developmental disorder may be due to hereditary factors, genetic abnormalities, injuries or diseases during the fetal period or in connection with childbirth. Acquired brain injury may be due to a traumatic brain injury due to an accident or illness in adulthood.

It is quite common that people with the diagnoses of developmental disorder and acquired brain injury have more disabilities, such as epilepsy, mobility impairment, cerebral palsy, autism, visual or hearing loss.

Difficulties with intellectual disability

Intellectual disability affects the cognitive functions, such as memory and abstract thinking. A person may have difficulty keeping many things in memory at the same time. He or she may have problems remembering, getting on, and getting started. The person may also have difficulty sorting out important information, interpreting and using information.
All people are different. Developmental disorder or equivalent causes difficulties in different ways and to varying degrees. The disability may affect a person's perception of the environment which can make it difficult to find different places.

- Perception of time, which makes it difficult to understand different time indications such as hours, days and "then"

- Quality perception, which involves difficulties in arranging and grouping in different systems, for example that animals can have different subgroups such as dogs and cats

- Quantity perception, which is about being able to handle quantities measured in numbers, which means that it can for example be easier to produce a plate for each person in a group home instead of five plates

- Perception of cause and effect, which involves difficulties in connecting an action with an effect.

Different scopes of difficulty

Developmental disorder is divided into different levels - mild, moderate and severe developmental disorders, which entail different degrees of difficulty. The description below is a simplification of the difficulties different people may have. A person can also be easy and difficult for different things within the different levels.

Slight developmental disorder

A person with mild developmental disabilities can imagine things that are not self-perceived and can learn to read, write and count. But the person may have difficulty understanding abstract concepts and things that he or she cannot experience in concrete terms. He or she may have difficulty understanding symbols for different things, such as, for example, that credit cards correspond to money as a means of payment.

Moderate developmental disorder

People who have a moderate developmental disorder may be able to learn to read single, light words and to write their own name, but understand more if they get help from pictures. The people understand spoken language to a great extent and often they can communicate through speech, but they mainly understand things that they themselves have experienced.

Grave developmental disorder

A person with severe developmental disorder experiences reality as it is here and now. Through various forms of interaction, he or she can learn to recognize people, objects and situations. On the other hand, it may be difficult for the person to imagine something in the mind, if he or she does not at the same time get a sense of mind. People with severe developmental disabilities do not understand spoken language so well and cannot speak but often communicate with body language and gestures. The person can learn to associate words with certain actions and situations. Then the words function as signals and not as symbols. For example, a spoon can signal dinner.

Acquired brain damage

Even people with acquired brain damage may have different degrees of difficulty. But they have got their disabilities later in life. In the Act on support and service for certain disabled people, LSS, the term "permanent disability" is used. But you talk more often about cognitive difficulties, which among other things involves problems with concentration, perception, memory.

Abuse, traffic accidents, drowning incidents and attempted suicide are examples of external violence that can cause permanent brain damage. Neurological diseases can also cause cognitive difficulties. People with acquired brain damage must once again learn the abilities they had previously. Anxiety and depression are common when someone becomes aware of their loss of past abilities and social networks.

Support and efforts

People with intellectual disabilities have different needs for support. The need for support depends on the person's abilities, difficulties and needs. A person with intellectual disabilities develops throughout his life. The support given must therefore be monitored regularly. When a person needs several initiatives, coordination between different actors is required.

According to the Education Act, only the children and young people who have a developmental disability can be received in the special school or upper secondary school.

Structure of everyday life and help to pay attention to health problems
A person with intellectual disabilities may find it difficult to see their own needs. Therefore, one may need help with getting structure on their everyday life. Aids, such as reminder tools and time aids, can make life work better. The person may also find it difficult to interpret his or her body and, for example, convey where he or she is hurting. Therefore, others in the person's vicinity need to be aware of whether he or she changes their behavior in any way. The person may also need help with being motivated to seek medical attention and help contacting the carer.

Common efforts

Persons who have a developmental disability or an acquired brain injury may be entitled to contributions according to the Act on Support and Service to Some Disabled People, LSS. In order to receive LSS contributions, the applicant must be covered by the law's personal circle and need the applied effort. The right applies if the need is not met otherwise.
People covered by LSS can also apply for support under other laws, such as the Social Services Act, SoL. Both SoL and LSS emphasize the importance of a holistic view of the individual's situation.

Some initiatives according to LSS can also be obtained as aid according to SoL. This applies to, for example, escort service and contact person.

Common efforts for people who are covered by LSS are, for example, the following:

- Daily activities should offer the individual stimulus, development, meaningfulness and community according to the person's wishes. The daily activities can include activities with habilitating focus and more production-oriented tasks.

- Housing with special service is a full-fledged home with common areas where support, service and care can be provided around the clock.

- Companion service means that a companion facilitates people with disabilities to participate in social life. The intervention should have the character of personal service and be adapted to the individual needs.

- A contact person can help with social contacts, participate in leisure activities and give advice and support in everyday life.

Support for relatives

Relatives of people with disabilities may also need support. Actions that indirectly support relatives include short-term stay and replacement service. Short-term stay means that a person with disabilities can be offered environmental change and recreation. Relatives can thus also receive relief in the nursing work. Replacement service in the home according to LSS means that another person temporarily takes over the care of a person from the parents. It can apply to both children and adults who live with their parents and belong to the LSS personal circle.

National competence center Relatives, NKA

National competence center Relatives, NKA, wants to contribute to the development of future family support. NKA provides information on family support, current events, research and development within the family area. NKA has a learning network that provides the opportunity to exchange knowledge and experiences with others. Children of parents with developmental disabilities

When children are born in a family where one or both parents have an intellectual disability, there is often uncertainty and doubt about the staff in the care and care how they can best provide support to the child as a relative. Personnel from different authorities and businesses are often involved in different ways in the children's and parents' everyday lives. In order for support and efforts to be provided in such a way that both children and parents receive their needs, the staff must cooperate with the families.

Source:
** text from Kunskapsguiden.se*

(a national website that gathers quality-assured knowledge from several authorities and other players. The National Board of Health and Welfare is the responsible publisher of the Knowledge Guide.)

Conclusion

Working with inclusion in activities for people with disabilities means utilizing the diversity and differences that exist within the organization by ensuring equal value for everyone and the right to an equal education with respect for the individual.

Accessibility means that the Learning provider develops knowledge about the conditions for learning and how it is related to the educational, social and physical environments of the activity. In this work is to identify and eliminate obstacles and actively work to develop and improve the entire organizations learning environment.

The need for adaptations depends on the individual and their specific needs.

CHAPTER 5: INCLUSIVE TEACHING AND ACCESSIBLE LEARNING

5.1 Introduction

This chapter is based on several “mainstreaming” documents in the domain of teaching disabled people. One important document is: “Embracing Diversity: Toolkit for Creating Inclusive, Learning-Friendly Environments” from UNESCO, 2015[4]:

An inclusive, learning-friendly environment (ILFE) welcomes, nurtures, and educates all children regardless of their gender, physical, intellectual, social, emotional, linguistic, or other characteristics. They may be disabled or gifted children, street or working children, children of remote or nomadic peoples, children from linguistic, ethnic or cultural minorities, children affected by HIV/AIDS, or children from other disadvantaged or marginalized areas or groups.

“All Children Are Different,” and all have an equal right to education, no matter what their background or ability. Many of our schools and educational systems are moving towards “inclusive education” where children with diverse backgrounds and abilities are sought out and encouraged to attend ordinary schools. On the one hand, attending school increases their opportunities to learn because they are able to interact with other children. Improving their learning also promotes their participation in family and community life. On the other hand, the children with whom they interact also benefit. They learn respect and to value each other’s abilities, no matter what they are, as well as patience, tolerance, and understanding. They come to realize that each person is “special” and to embrace diversity and cherish it.

For teachers, embracing such diversity in our students is not an easy task. Some of us may have large classes, and we may already feel overworked. Including children with diverse backgrounds and abilities in our classes often means more work, but it need not be so. All we need to do is to manage the differences among our children by recognizing their strengths and weaknesses, planning lessons accordingly, using teaching strategies and adapting our curriculum to fit each child’s abilities and background, and, most importantly, knowing how to mobilize our colleagues, parents,

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community members, and other professionals to help us provide a good quality education for all children.

5.2 Creating Inclusive, Learning-Friendly Classrooms: How Children Learn

No child is “learning impaired.” Given the right conditions, ALL children - girls and boys - can learn effectively especially when they “learn by doing.” For many of us, we learn best by “learning by doing,” that is, through actually doing activities and gaining experience. This is what we really mean when we talk about “active learning,” “children’s participation in learning,” or “participatory learning.” It’s getting children to learn new information through different activities and teaching methods. These activities are often linked to children’s practical experiences in everyday life. This linkage helps them to understand and remember what they are learning and then to use what they have learned later on in life. What are some of the different ways that children learn? Knowing these different ways will help us to develop learning activities that are more meaningful for children and us. They will help especially those children who have traditionally been excluded from learning but who we want to keep in our inclusive, learning-friendly classrooms.

5.2.1 Sensory Learning: Sight, Sound, and Movement

What are your children doing when they first come into your class in the morning? Hopefully they are looking at you (sight), listening to you (sound), and watching what you and others are doing (movement). THEY ARE LEARNING

Over the years, we have learned that 30% of children learn successfully when they hear something, 33% when they see something, and 37% through movement. As the old saying goes, “I hear and I forget; I see and I remember; I do and I understand.” This is very important! If we only teach children by having them listen to us, then only about one-third of our students is learning anything. The same situation exists when we ask them only to write something down in their notebooks.

For teachers, this means that when we are planning lessons, we need to plan to use visual materials (posters, drawings, etc.), to use tasks that involve discussion (hearing and listening), and to provide opportunities for movement of some form (for example, drama or dance that is possibly linked to the different cultures represented in your classroom). Remember that some children may have sight or hearing difficulties and will not receive the same sensory input as other children. Ask yourself, “What activities will be relevant to them, and how can I as a teacher adapt an activity to make it more relevant so ALL of my children can learn?”

Active and participatory learning can use the many ways that help children to learn. Seven pathways by which children learn include the following.

1. Verbal or linguistic, where some children think and learn through written and spoken words, memory, and recall.
2. Logical or mathematical, where some children think and learn though reasoning and calculation. They can easily use numbers, recognize abstract patterns, and take precise measurements.

3. Visual or spatial, where some children like art, such as drawing, painting, or sculpture. They can easily read maps, charts, and diagrams.
4. Body or kinaesthetic, where some children learn through body movement, games, and drama.
5. Musical or rhythmic, where some children learn best through sounds, rhyme, rhythm, and repetition.
6. Interpersonal, where some children learn easily in groups through cooperative work. They enjoy group activities, they easily understand social situations, and they can develop relationships with others easily.
7. Intra-personal, where some children learn best through personal concentration and self-reflection. They can work alone, are aware of their own feelings, and know their own strengths and weaknesses

We need to develop lesson plans and manage classrooms in ways that ensure active and effective learning for all children. We'll learn more about lesson planning in the next Booklet on managing inclusive, learning-friendly classrooms.

5.2.2 Children Actively Create Their Own Knowledge and Meaning

Children learn by linking new information with information that they already know. This is called mental construction. Talking and asking questions together (social interaction) can improve learning, which is why pair and small group work is so important. Our role as teachers is not to pour information into children's minds; neither is it right to leave children to discover everything for themselves. We should actively find ways of supporting learning that use information that the children already know (their prior learning). A child might be slow to adjust to learning in school, and he or she doesn't know what to say when you ask a question. In this case, you will need to establish a good relationship with the child so that you can understand how the child learns best. For example, what simple tasks can this child do? What letters in the child's name does she know and can copy legibly? Which numbers does she know and can associate with simple objects in the room? What are the special things this child likes and can talk about to the teacher, to another child, or even to a simple hand puppet in the classroom? Can this child sing or play games?

5.2.3 Tips for Teaching and Learning

- Lessons need to be structured around "big ideas" rather than unconnected pieces of information. In this way, children have an umbrella under which they can fit new information with what they already know. A big idea can be something like "water is important to life," and the topic could be "today we will learn how to keep water clean."
- We need to consider children's developmental needs. Some children will need more time to progress than others.
- We need to be facilitators of learning and recognize the unique characteristics of our learners. The learning environment should support all learners.
- Students need to talk together with their teacher and with one another during activities that are both individual and team-oriented.
- We need to plan activities that encourage ALL children to work as a team, such as working in pairs or small groups on relevant tasks.

- Students must be able to find the curriculum useful to them, be encouraged to ask questions and consider information, and be able to construct their own understanding of the subject matter.
- We need to ask good questions to allow students to explain their ideas. Rather than asking questions that require a “Yes” or a “No” answer only, we need to ask open-ended questions to allow children to express their views, ideas, and opinions; for instance, we can ask questions that end with “what do you think?”
- Thoughtful questions asked by the teacher and active discussion among students will stimulate children to search for information. Interacting with others, receiving new information, and reflecting on ideas help children to construct new knowledge

5.2.4 Action Activity: Gift Giving - Getting to Know Each Other

Teachers in a cluster group can use this activity when they meet for the first time. They can also use it when they meet their students at the start of a school year or even at the first Parent-Teacher Association meeting. For this activity, participants work in pairs. They should ask each other open-ended questions to find out what special qualities each person has that would benefit the group. The final statement should be written on a small “gift card” and state something like: “My friend’s name is .... and he brings the gift of patience.”My friend’s name is ....and she brings the gift of a sense of humour.”

Each pair of participants then takes turns in presenting each other’s kills to the entire group. They should talk about how these skills can benefit everyone. The teacher, or other facilitator, should also have decorated a box into which each participant drops his or her gift card after presenting their friend to the whole group. This activity can highlight the need for teachers to value all children in their class, and that many personal qualities are not obvious to the casual observer. Our responsibility is to scratch the surface and discover the unique quality that each child possesses. We can then set up learning experiences that allow these qualities to be developed and used.

Teachers need to devise different ways of learning using different teaching methods, so that all children can understand the information we are teaching and can learn in a meaningful way, especially those with diverse backgrounds and abilities.

The range of teaching-and-learning activities in the classroom runs from memorization and repetition all the way to solving problems and thinking creatively.

In our classrooms, we can look for ways to address this entire range. For example, we can:

- use blocks, models, and other objects to teach mathematics, which taps into children’s fine motor skills and their visual understanding;
- invite children to talk about (or write about) ideas and processes in mathematics, which links their verbal thinking to understanding mathematics concepts;

- ask children to draw pictures for the stories that we read to them, which connects their visual thinking to the words and events in the story; and
- guide children in making maps of the area around school, which links their experience of movement in space to visual and mathematical concepts. When children survey their community, identify problems within it, and use their skills cooperatively to suggest solutions to these problems, they are learning how to apply what they learn in school. Apart from being good education, this process helps the community to understand the work of the school, and they may be more motivated to support the work of teachers.

For a classroom to be fully inclusive, you need to make sure that the curriculum is accessible to and relevant for ALL children in terms of what you teach (content), how you teach it, how the children learn best (process), and how it relates to the environment in which the children are living and learning.

We also need to consider those children who have learning difficulties or show learning faltering. Are we planning for those children who may have difficulty with the standard curriculum, such as those children with visible physical, sensory, or intellectual impairments, or children from poverty-stricken families, or those who do not speak the language of instruction? Will the curriculum still be accessible to these children as well as others? How can we go about this?

5.2.5 Action Activity: Observing Diversity

1. Write down the children in your class who have clear strengths in certain subjects, such as mathematics, writing, discussion skills, etc. Describe how these strengths are demonstrated in class.
2. Write down the children who have other talents that may be indirectly related to classroom learning. Is one child a good model maker? Does another show good coordination in sports and games? Does another have very good social skills? For instance, children with Down’s syndrome often have very good social skills.
3. Now draw a circle on the page to represent the rest of the children in the classroom that you haven’t linked to special skills or talents. In the next week, observe these children more closely. If you notice that one of them likes a certain activity, write it down. How does this activity or how the child performs it reflect his or her ways of learning? How can these ways be incorporated into your lessons?

In observing and dealing with diversity, we need to identify what provisions we can make, that is, the positive ways of helping children to learn, especially those with learning difficulties. We should not focus on what we have to “give up” (concessions), such as our time, but on the learning benefits for our children. For instance, can we ask another child to read to the child and be his writer? At the same time, can we identify what valuable skills a child with difficulties has, and how his or her partner can learn these skills? In other words, we need to establish a relationship where both children are able to contribute to each other’s learning.

5.2.6 Equity

Equity in curriculum design, therefore, is important for ensuring inclusiveness in the classroom. The teaching materials we use are inclusive when they:

- include ALL children, including those with diverse backgrounds and abilities;
- are relevant to the children's learning needs and abilities, as well as their way of life;
- are appropriate to the culture;
- value social diversity (for example, socio-economic diversity; poor families can be very good families for children; they may come up with creative solutions for problems, and they could be depicted as inventive);
- are useful for their future life;
- include males and females in a variety of roles; and
- use appropriate language that includes all of these aspects of equity.

How can you assess whether or not the materials you are using reflect gender and ethnic equity?

1. Check the illustrations. Look for stereotypes, that is, images or ideas about people that are widely held and accepted though they may not necessarily be true (such as men as "breadwinners" and women as "child care providers"). In the illustrations, are people of one cultural group or men the dominant characters? Who is doing what? Are children with disabilities passive watchers, or are they involved, such as playing ball with others? Do they look enthusiastic?
2. Check the story line. How are problems presented, conceived, and resolved in the story? Does the story line encourage passive acceptance or active resistance by "minority" characters (such as tribal peoples or persons with disabilities)? Are the successes of girls and women based on their own initiative and intelligence, or are they due to their "good looks"? Could the same story be told if the actions or roles given to men and women in the story were reversed?
3. Look at lifestyles. If the illustrations and text attempt to depict another culture, do they simplify or offer genuine insights into other lifestyles?
4. Look at relationships. Who has the power? Who makes decisions? Do women function in essentially supportive yet subordinate roles?
5. Note the heroes. Are the heroes usually from a specific cultural group? Are persons with disabilities ever heroes? Are women ever the heroes? Are poor persons ever heroes?
6. Consider effects on child's self-image. Are there any suggestions that might limit any child's aspirations? This might affect children's perceptions of themselves. What happens to a girl's self-image when she reads that boys perform all of the brave and important deeds but girls don't?

When we are creating inclusive classrooms and are trying to include children with a range of abilities, we need strategies to help these children learn to their fullest. Some of these strategies include the following.

- Sequence. Break down tasks and give step-by-step prompts or instructions.

- Repetition and feedback. Use daily testing of skills, repeated practice, and daily feedback.
- Start small and build. Break down a targeted skill into smaller units or behaviors, and then build the parts into a whole.
- Reduce difficulty. Sequence tasks from easy to difficult and only provide necessary hints.
- Questioning. Ask process-related questions (“how to”) or content-related questions (“what is”).
- Graphics. Emphasize pictures or other pictorial representations.
- Group instruction. Provide instruction or guidance for small groups of students.
- Supplement teacher and peer involvement. Use homework, parents, or others to assist in instruction.

5.3 Helping Children Who Do Not See Well

When a child who has difficulty seeing first comes to the school, meet the child and the parents alone. Let the child know who you are by talking with the child and explaining what you are doing. Let the child touch you. Next, introduce the child to his or her classmates. Explain that this child goes to school like everyone else, and he or she can do many things

using their other senses, such as touch, hearing, and smelling. Suggest that while the child may need some help with specific tasks, they can all learn from each other.

Introduce the classmates to the child. If the child cannot see them, tell the child the names of some of the children. Let the child speak with each one of them until the child remembers their voices and names. Let the child touch them. Then tell the child the names of the other children so the child will begin to know all the children in the class. Children with difficulty seeing usually do not know when people are near them. They cannot see which person they have met. When you are with a child who cannot see well, speak to him or her, so the child will know that you are there. Tell the children in your classroom to do the same.

Write on the blackboard using large letters and teach your children to write in this way. Read out instructions; never assume that everyone can read them from the blackboard. Specify what is shown on visual aids (such as “on the left side is ...”). Allow children to feel teaching aids if they cannot see them; for example, maps can be outlines with string. Each child who has difficulty seeing needs a reader to help him or her. The reader will read and explain books to the child and help the child to learn. The reader can be a classmate, an older child, a friend, or a volunteer teacher. A child who can partially see may be able to learn to read and write in the same ways that other children learn. Teach the child first to write letters and numbers. You can start to teach the child to write with chalk on a slate. Fix pieces of string across the slate so that the child can touch and use them as guidelines while writing. When a child begins writing on paper, fix the strings in the same way on a piece of wood. Teach the child to place the paper under the strings.

5.4 Children Who Have Difficulty Hearing or Speaking

Children who have difficulty hearing or speaking often do not communicate, or they communicate poorly. This is because although we use different ways to communicate, we use hearing and speaking most often.

Children Who Have Difficulty Hearing or Speaking

Children who have difficulty hearing or speaking often do not communicate, or they communicate poorly. This is because although we use different ways to communicate, we use hearing and speaking most often. Identifying Children Who Cannot Hear Well

Some of the signs that can tell us if a young child is having difficulty hearing include the following.

- The child does not notice voices or noises if he or she does not see where they are coming from.
- The child is disobedient or is the last person to obey a request.
- The child's ears are infected, or liquid or pus is coming out.
- The child watches people's lips when they are talking.
- The child turns his or her head in one direction in order to hear.
- The child speaks rather loudly and not very clearly.
- Sometimes the child appears to be quiet and perhaps rude and prefers to be alone.
- The child may not do as well at school as he or she should.

Communicating with a Child Who Has Difficulty Hearing

Some children who are born without hearing may not learn to speak. They should be taught other ways to express their thoughts, needs and feelings, such as artistically or through movement and gestures. If there is a child in your class who cannot hear or speak, use different communication. Before speaking to the child, get the child's attention, so he or she

will know that you are speaking. Make sure that the child can see you clearly. Stand in the light so that it falls on your face. Children who have difficulty hearing or speaking are sometimes irritable. They may pay attention, or they may not listen carefully to what is being said. Observe them carefully. If they do not pay attention, find ways to make them interested in what you are saying. For example, seat yourself and your children in a circle so everyone can see each other's faces. This will help listening and understanding. Use visual clues to introduce the lesson, such as a picture, object, or key word. Some children who have difficulty hearing can hear more clearly if others speak close to their ear. Find out if this helps the child you teach. If so, speak close to the child's ear when you communicate with him or her. Tell other children to do the same. When you communicate with the child give him or her time to listen and to think. If the child responds by making sounds that are not proper words, repeat correctly and slowly the words the child has tried to say. Make sure that the child can see your face as you say the words correctly. When you speak, move parts of your body to make what you say clearer to the child who has difficulty hearing. Also use your hands when you speak; for example, you may use your hands to show the size of objects. Use movements and expressions as often as possible whenever you are with the child who has difficulty hearing. The child will then learn what these means. Teach the other children to use expressions and movements to communicate with the child who has difficulty hearing. Try to understand the different ways in which the child expresses himself or herself. Also continue using different methods of communication with the child to make him or her understand what you want.

5.5 Making Learning Meaningful for ALL!

5.5.1 Preparing for Meaningful Learning

"Meaningful learning" means that we link what is being learned (the topic or content) and how it is taught to the everyday lives of children and their families. As we all know, teachingis a complex activity. We must consider many things when preparing for meaningful learning. Above all, no one can make a child learn. Children will learn when they are motivated to learn.

They will learn when given opportunities to learn effectively and when they feel that the skills they have will lead to success. They will learn when they receive positive feedback from friends, teachers, and parents who compliment them on how well they are learning. How can we prepare for meaningful learning? Here are some questions to be asked in preparing lessons.

- Motivation. Is the topic meaningful and relevant to the children? Are they interested in what they are expected to learn?
- Opportunities. Are the opportunities suited to the developmental level of the children? For instance, is the topic too hard or too easy for many of the children? Are the activities appropriate for both girls and boys? Are they appropriate for children with diverse backgrounds and abilities?
- Skills. Do the children have the skills to achieve the expected result?
- Feedback. Is the type of assessment and feedback given to the children designed to increase motivation to continue learning

In a learning-friendly classroom, you must play different roles. In the past, our role has been that of an "information giver." But in order to help our children learn to their fullest, we must expand our role to that of facilitator, manager, observer, and learner. What do these new roles entail?

- Facilitator. We need to provide appropriate learning opportunities for children and encourage them to freely present ideas and talk about important issues in a constructive manner
- Manager. To be a successful facilitator, we must plan well and carefully guide the discussions, giving every child a chance to express their views.
- Observer. Observation of the children as they work in a group, in pairs, or alone will help us to understand the children and to plan even more

meaningful learning activities. For instance, can an activity that a pair of children is doing well be expanded into a group activity? Can the two children be the group's leaders?

- Learner. We become learners when we reflect on our lessons and how well the children have been learning. We can then develop ways to make what is being learned even more meaningful. For instance, was one activity effective in helping children to understand a difficult topic or concept? Can this activity be applied to other topics and concepts?

5.5.2 MAKING MATHEMATICS, SCIENCE and LANGUAGE MEANINGFUL for ALL

Mathematics, science, and language (reading and writing) are the core subjects in most of our schools. They are also the most challenging for children. In all of these subjects, children learn abstract concepts that may be difficult for them to understand, unless your children can link these abstract concepts to what they do in their daily lives. Once they make this connection and can understand an abstract concept, they can start applying it through one or several important skills. The following sections will give you some ideas about how you can make these subjects more learning-friendly for all of your students and more fun for you to teach.

Learning-Friendly Mathematics

We use mathematics when we guess how long it will take us to walk home. We use mathematics to estimate how much water will fill a bucket, and how much three kilograms of potatoes will cost at the market. We use mathematics when we are selling fish at the side of the road. We use mathematics when we dance (numbers of steps), when we play music, and when we sing (use of rhythm and time).

Use Different Teaching Methods: DO, TALK, and RECORD

In developing their mathematical skills, children need to be involved in doing practical activities; they need to learn how to talk about mathematics; and they need to record (write down) how they have tried to solve mathematical problems.

- The DO part of this process relates to the activity (for example, counting out the beans and then subtracting some).
- The TALK part is a discussion with a partner or in a small group, such as "I think it should be 6 not 5 because...."
- The RECORD part entails writing down the process of finding the answer, so that the teacher can talk with the child about other ways to solve the problem. For example, children can be asked to measure certain shapes and work out perimeters and areas (DO). Each group can discuss their measurements (TALK). Each group's results can be combined with those of other groups and then written down to show the results of the entire class (RECORD). Class discussion is likely to follow.

5.6 Planning for Teaching and Learning: Classroom routines

Regular classroom activities help children to start work quickly and meaningfully at the beginning of their school day. Children should agree on the rules and routines and, better yet, they should organize them. For example, a student group or committee can be in charge of taking the register and reporting to the teacher about absences.

When developing routines with children, it is important to explain and decide upon: (i) what is to be done; (ii) who is to do it; (iii) when is it to be done; and (iv) why is it important to do this routine activity regularly.

Following are some ideas about routines that you can organize with your children:

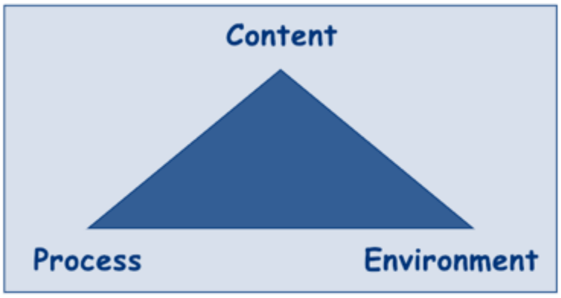
- what work they need to do at any one time, particularly for those who may arrive late because they have far to walk, as well as for those children who are waiting for the class to start;
- how books and other learning materials should be distributed, collected, and stored, and who should take responsibility for these activities (perhaps rotating this responsibility among individual children, girls as well as boys, or teams of children);
- how children can get help from each other when they need it and the teacher is unavailable;
- what to do when they have finished an activity;
- how to get the teacher's attention in a non-disruptive manner;
- what are acceptable levels of noise;
- how to move around the classroom in a non-disruptive manner; and
- how to leave the classroom.

Children should actively develop some of these rules because they are more likely to abide by them if they have participated in setting the rules. However, some rules may be non-negotiable, especially when they are intended to protect children; for instance, rules about when they can leave the classroom, or rules about contacting the teacher before leaving the school grounds, especially if they are being accompanied by an adult who is not their parent or guardian.

5.7 Lesson planning

To make the best use of your time and the time available for learning, lessons need to be well planned. Of course, this takes time at first, but it is an important professional skill for all teachers, and a time-saver in the long-run.

One framework that can be used for planning is the curriculum triangle.



In this framework, content means what topic has been identified in national curriculum documents. However, and especially for classrooms containing children with diverse backgrounds and abilities, this topic needs to be meaningful to the children and adapted to fit the local community in which they live.

Process is how the content is taught. This may involve using different teaching methods to meet the needs of different learning styles or in order to maximize the time available for teaching and learning (see peer tutoring below).

Environment includes the physical environment—including learning resources for lessons that could be available in learning corners—as well as the psycho-social environment; for instance, an emphasis on building self-esteem through cooperative group activities.

Children learn best when they are active and thinking. They also learn well when activities are based on real life experiences and contexts so that they can apply their knowledge more effectively. Teachers who know their children and community well can more easily include local examples when planning lessons. Unfortunately, however, many teachers have never been guided towards planning lessons. They have been taught to rely on textbooks. In some cases, this is because a textbook is the only available teaching aid.

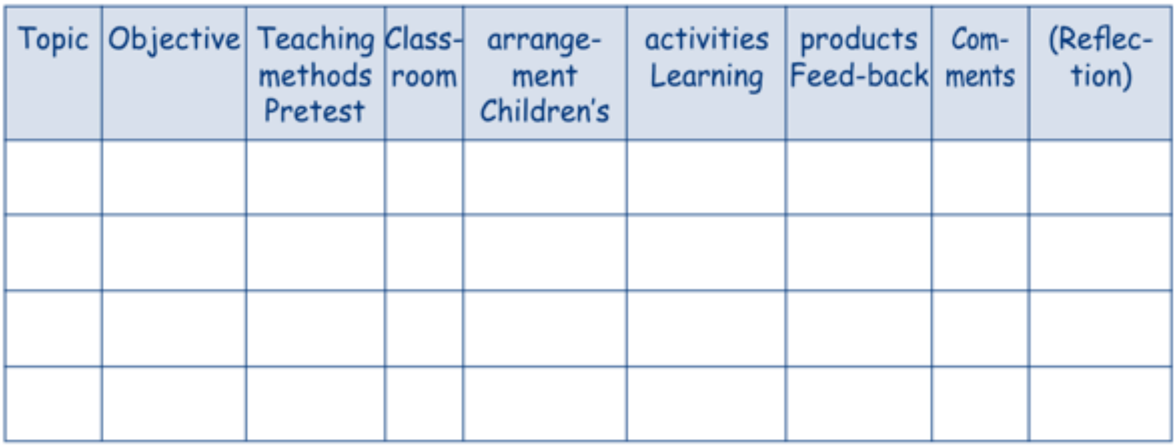
In any case, they must plan how to communicate the information in the textbook in a manner that their children will understand. For the inclusive classroom, this planning is not a luxury, it is a necessity because we must consider the needs of children with diverse backgrounds and

abilities. We need to know at least the following.

- What are we teaching (topic, content)?
- Why are we teaching it (goals/objectives)?
- How are we going to teach it (methods/process)?
- What do the children already know (prior learning; pre-testing)?
- What will the children do (activities)?
- How will we manage the lesson (including organizing the physical and social environment)?
- Will activities be appropriate for ALL children?
- Will the children have the opportunity to work in pairs or small groups?
- How will children record what they have been doing (learning products, such as drawings)?
- How will we know if the children have been learning (feedback and assessment)?
- What do we do next (reflection and future planning)?

Some of the ways we can organize ourselves and plan our lessons well is through using a simple lesson planning matrix, a lesson plan outline, or a daily lesson planning format as in the examples here. Try to use at least one of them in planning your lessons; maybe start with just one topic or lesson. They will give you a firm start in organizing your teaching; a way to monitor whether or not children are understanding what is taught; and a chance to think about what to do next and how to improve your teaching

Lesson Planning Matrix



Topic	Objective	Teaching methods Pretest	Class-room	arrange-ment Children's	activities Learning	products Feed-back	Com-ments	(Reflec-tion)

Lesson Plan Outline

Subject: ___________________________________

Class or Teaching Group: ___________________________________

Number of Children: ___________________________________

Time: ___________________________________

Learning Objectives: What do you want the children to learn in this lesson? Think about the knowledge, skills, and attitudes you want them to learn. Choose two or three to focus on in one lesson.

Resources: What resources do you need for the lesson? What materials do the children need? How can the children help to obtain resources?

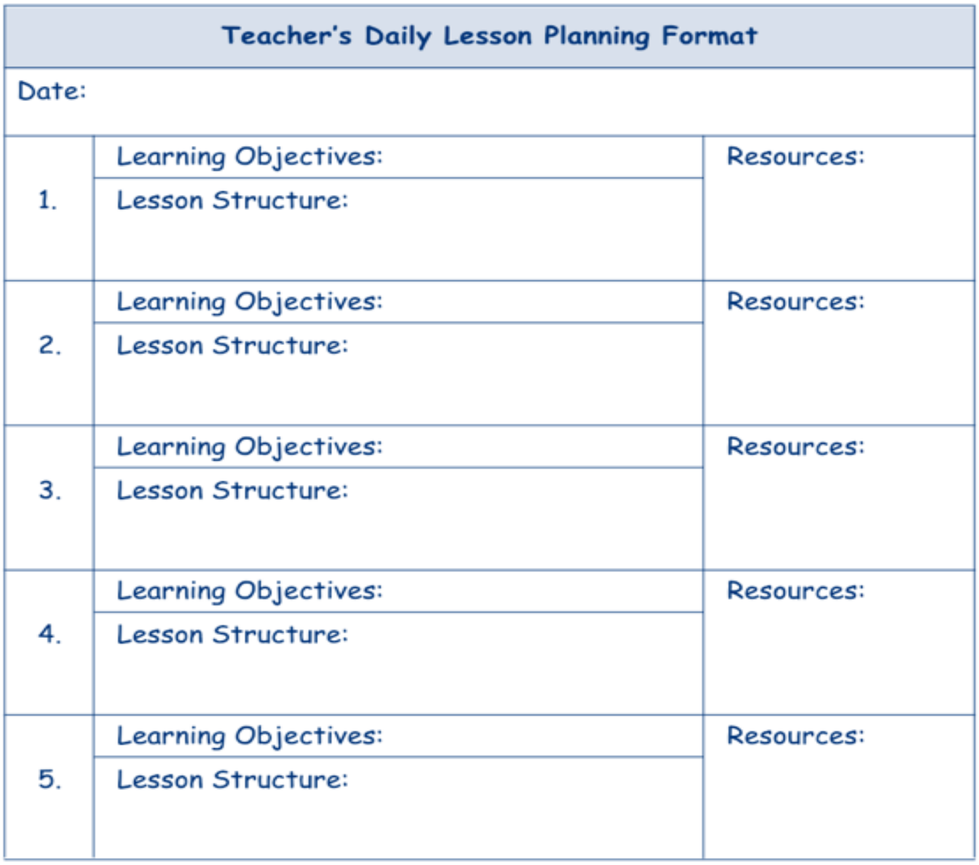
Children with More Individualized Needs: Are there children in the group who will need extra help? What kind of support will you need to provide to these children? Do you need to help them on an individual basis? Do you need to make sure that they are sitting in an appropriate place in the classroom? (Often it helps to have children who need extra help at the front of the room where you can easily help them, especially if your classroom is crowded.)

Introduction: Tell the children what you want them to learn in this lesson. Some teachers write this on the board at the start of the lesson. Think about how you will start the lesson. Remember to review briefly what the children learned in the previous lesson. Try starting with a problem for the children to solve, with an open-ended question, or with a picture to discuss that can lead on to your main activities.

Main Activities: What do you want the children to do in the main part of the lesson? Make sure that your tasks ensure that the children will reach the learning objectives. Try to include a variety of activities; for example, try asking the children to work in pairs or small groups.

Decide how you will introduce and explain the tasks. Decide how you will spend your time when the children are working on a task. This is often a good time to support children who need extra help.

Conclusion: Choose an activity or discussion at the end of the lesson that reinforces the learning objectives. Ask the children what they have learned.



Teacher's Daily Lesson Planning Format		
Date:		
1.	Learning Objectives:	Resources:
	Lesson Structure:	
2.	Learning Objectives:	Resources:
	Lesson Structure:	
3.	Learning Objectives:	Resources:
	Lesson Structure:	
4.	Learning Objectives:	Resources:
	Lesson Structure:	
5.	Learning Objectives:	Resources:
	Lesson Structure:	

5.8 Managing behaviour in the in Clusive ClassrooM

Children may misbehave if they are not noticed or cared for. They may need attention, particularly if they are not receiving adequate care or attention at home. Moreover, we (as adults) may disapprove of certain behaviours, but this should never mean disapproving of the child as a person. It is important to separate the behaviour from the child! Some of the ways to deal with misbehaviour include the following.

- Classrooms need one main rule, namely: Respect One Another.
- If we create an interesting curriculum with materials that are meaningful to children, then they will be interested and become involved.
- We need excellent observation and recording skills to determine what causes a particular behavioural problem.
- Most importantly, we need to create an environment where children are actively engaged and motivated. That will be good teaching for all children. It also means the teacher is not always the person in control, but she is one of a team of problem-solvers including children, parents, and other teachers.

Other common strategies for content area instruction and solving behaviour problems include peer tutoring and cooperative learning.

5.8.1 Problem-Solving Approach

A problem-solving approach involves a team consisting of the child, parents or caregivers, teachers, and external professionals who ask questions about the classroom's physical environment, social interactions, instructional environment, as well as non-school conditions. As we learned in the Tool on bullying, it is not just the behaviour we

are interested in but the reasons for this behaviour. We need to know something about children's needs and what they are trying to communicate

5.9 Four good practice examples,

Selected by Inclusive Europe, Source: https://inclusion-europe.eu/wp-content/uploads/2018/02/Best-Practice-Education_EN-FINALWEB.pdf

5.9.1 Cleves Primary School, London, United Kingdom

An inclusive school within an inclusive authority, Cleves Primary School is a prime example of how a policy to include all children in mainstream schools can look in practice. In a fully accessible environment at the heart of a changing inner city multi-ethnic community, Cleves lives out the dream of a mainstream school place for any child. Key factors towards achieving this are: a) a deeply rooted ethos of valuing and celebrating diversity, b) innovative staffing structure & curriculum delivery and c) strong partnerships with outside agencies as well as with the governing body, parents and the local community.

Strengths:

- Implementing policy in practice
- Peer support and relationships
- Character of additional support and its organisation

Cleves Primary School was set up in 1992 as a resourced school in the London Borough of Newham, a Local Authority known for its strong commitment to inclusive education. The most recent report on local variation of implementation of national legislation and guidance found that in 2004 Newham had the lowest percentage in the country of pupils placed in special schools (0.06%). Whereas other Local Education Authorities were placing around 1 in 68 children in special schools (1.46%), in Newham the figure was closer to 1 in 1,667. The school implements the borough's policy of Inclusive Education and has 32 places for children with high level support needs including pupils with multiple and profound learning difficulties. The school has the capacity for 420 Primary pupils with a 52 FTE (full-time-equivalent) place Nursery.

All staff, parents/carers and children who are admitted to the school are fully aware of its inclusive nature. This is very obvious from the organisation and management of the school and the variety of equipment and resources available. Some parents and colleagues in different services may at first feel ambivalent about the value of an inclusive setting such as Cleves, but staff has come to expect that newcomers soon recognize that a school that includes children with high-level support needs is good for all the children and families in the community. In reality this means that the school thinks much more carefully about the structure of the school day, the way teaching and learning is organised and the monitoring and evaluative processes. Like all schools, Cleves faces the challenges of a changing educational world and all the implications of that in a school that has such a wide range and diversity of children.

Over 82% of pupils on roll come from a variety of ethnic minority communities and have a first language that is not English. The children speak 29 different languages; other than English the main first languages are Bengali, Urdu and a variety of African languages. Cleves is committed to providing good primary practice that is flexible and holistic in meeting the needs of the diverse school community. The school is working towards being a people centred school. The aims of the school include:

- *to provide an environment where each child of every race, gender, class and learning need is truly recognized, accepted and valued;*
- *to create an environment where there is a place for everyone and there is a feeling of belonging;*
- *to develop high positive self-esteem in all children and adults;*
- *to enable children to be aware of their interdependency on each other*

All policies and procedures take into account the diversity of children, staff and community that use the school; for example, the behaviour policy is based on developing relationships that take into account issues associated with children with challenging behaviour. The ethos of the school is based on the celebration of difference. This is reflected in every aspect of school life, for example the organisation and structure, the curriculum and the learning environment. The ethos of the school is for children to work together and support each other. Children work and learn in groups that include all the children.

There are a number of organisational and management structures that promote inclusion throughout the school. For example, there is a playtime at lunchtime but there are no playtimes in the morning or afternoon; instead, many opportunities for physical activities and social interaction are built into the daily curriculum. The wings (see below) have access to the PE (Physical Education) Hall for a whole day so that there is adequate time for children to develop self-help skills. Lunchtime is seen as part of the curriculum with lots of adults supporting children and having lunch with them. The curriculum organisation is structured in a similar way to a secondary school, for example staff planning and teaching a curriculum area for several weeks with the children moving to the area dedicated for that subject.

With regard to the physical environment, the school is a single storey building with full access to all teaching and toilet areas for children and adults with mobility difficulties. There are specialist hygiene facilities, which allow for medical and other personal needs of pupils and adults to be met with dignity. The design of the school building is unconventional, in that the school has four Open Plan Wings: Early Years (Nursery and Reception groups), Key Stage 1 (Years 1 and 2), Key Stage 2A (years 3 and 4) and Key Stage 2B (years 5 and 6). The school also has a practical room with a kiln and facilities for clay work, two strong rooms and a multi-purpose-dining hall as well as a separate large hall with a sprung floor, which has a wide range of PE apparatus. There is also a specialist sensory studio that is timetabled for all children to use, a soft playroom in the Early Years Wing, a ball pool in the foyer and a relaxation room for each wing to use. Finally, the playground has recently been developed and now has a stage, seats, musical instruments, climbing wall, goal posts, climbing frames and more.

For all purposes the wings are viewed as one large classroom with five defined curriculum areas and a team of staff who work together to plan and teach the curriculum. The organisation of the Wings enables children to learn through experience in a rigorous approach to the curriculum. There is a balance between directed activities for Literacy and Numeracy and opportunities for children to plan when, not if, they undertake activities in other curriculum areas. Staff ensures that experiential activities have the same place and status in the curriculum as abstract activities. The children use a daily diary to record or evaluate their learning. This enables all to take full part in the range of learning opportunities, gives staff an additional form of record keeping as well as an opportunity to discuss with the children the process of evaluation and to celebrate the children’s achievements. To ensure that the curriculum is appropriate and that the children are making progress and achievements, the school has adopted a rigorous process of monitoring and evaluation.

Contrary to the established UK system of one teacher in charge of a class of about 30 children and Learning Support Assistants providing one-to-one support for individual children, the staffing structure at Cleves is flexible: multi-disciplinary teams of teachers, nursery nurses and teaching assistants are led by Assistant Head Teachers to facilitate the learning of all children. This creative arrangement benefits everyone. Staff plans together to organise a differentiated curriculum that offers the best in good primary practice to all children. The success of Cleves seems to rely upon a deeply embedded philosophy of valuing diversity and a strong commitment to providing opportunities for all children to interact and learn from each other, as a means towards a more inclusive society of the future. In the words of a teacher: “By providing opportunities for interaction I have seen all children flourish in ways we had possibly been denying them.” In the words of a 10-year-old pupil responding to the question: What do children with complex needs teach us?: “You have to take care of everyone because if we don’t care life will be sad. It is our responsibility to care.” There are many mainstream schools that, like Cleves, are constantly striving to develop inclusive provision for all learners. They have all devoted time and energy to review and to change their culture, their policies and their practice, seeing that as the key to inclusion.

Contact details of the school:

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Nominating organisation:

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5.9.2 Sophie-Scholl-Schule, Gießen, Germany

Sophie-Scholl-Schule in Gießen is an inclusive school for all children. Accepting and appreciating heterogeneity is emphasized in developing teaching methods, school rituals and activities. Multi- professional teams of teachers, educators and therapists work together and accompany all children during the school day and parents find many opportunities to cooperate with the school.

Strengths:

- Transition between different stages and forms of education
- Teacher training and development
- Changing attitudes of teachers and other staff

Sophie-Scholl-School in Gießen was set up as a private school in 1998 by members of Lebenshilfe Gießen, e.V. Up to then children with intellectual disabilities had been sent to special schools and had no opportunity to attend public schools. Currently about 260 children attend Sophie-Scholl-School. They work in 12 groups at different age levels. Classes are built across two grades. Up to 22 children attend each class and five of them usually have special needs. There are two teachers per class during the lessons. They are – depending on the needs of the children - assisted by educators, nurses and/or young people during their social year. In the afternoon pupils take part in an interesting afternoon-program with a big variety of courses children can choose. The school house was built with a strong commitment to inclusive education. Therefore it is fully accessible for everyone, and its atmosphere is bright and friendly. All people – children and staff – like to be in the building (to work, to learn, to grow, to live...). Since Sophie-Scholl- School is a private school, governmental subsidy has to be completed with parents' school fees. For afternoon-activities a special funding is necessary and a lot of work is done in an honorary capacity by parents and professionals.

Teaching methods

In an inclusive school methods, results and effects of learning must vary from child to child and also must be measured individually. It does not make sense to teach all children the same in the same way and to expect them to learn the same thing. In an inclusive school we choose working methods tailored to every single child and we vary within topics and subjects in such a way that all children can participate. If we want children to learn together but not to learn the same thing at the same time, we need to identify methods of teaching that allow diversity. A day in school is divided into several phases of work and leisure. The rhythm of the day is visualized by pictures on the black board. During the day we change phases of tension and relaxation, of partner-, team- and individual work.

For several periods each day we work with the "weekly plan" or, "plan for the day". We use this instrument so that every child can do his or her work on an individual level. Using the "plan" as the same instrument for all children is the chosen method. Within this frame everyone has working-time and has an individual workload and timing.

Another possibility in class is working on the same topic but with different tasks. Working in this way, firstly all of the class meets and the teacher summarizes the topic the class is going to work on. The pupils then ask questions and try to find interesting sub-topics which they would like to study. They also think about the methods with which they can get results for their questions. The ideas of the children contain experiments as well as reading and reproducing texts or the creative treatment of the topic (like building a model) up to useful training of a special tool. The different tasks have to be discussed with the teacher if they are invented by the children. Other tasks are instructions given by the teacher directly. If you have many different tasks concerning one topic it is very important to finally re-import results and working methods into the group: this is the reason why presentations are of very high interest.

The quality of teaching methods and class arrangements has to be very high to be successful in teaching a heterogeneous class. In the school team you can find a lot of reflection on different teaching methods and pupils' results in class. Class teams meet once a week to reflect on the work and make a plan for the next stage. Teachers visit each other in class to reflect on development or setbacks. Doing so we can learn from each other's experience – for the benefit of all.

If a problem persists they ask the school-principle to have a look at the situation, because she knows how to train teachers. Methodologies are at last created by those who are involved in daily practice. Since the school has *multi-professional teams* in every class, they can take various different viewpoints on the issues. In team-meetings and special instruction meetings they discuss and try to develop new ideas.

Recognition of Heterogeneity

The most important insight for teachers is the recognition and acceptance of all children being different. If we not only accept heterogeneity but really understand that all of us profit from others, we will be ready to develop truly inclusive schools and societies.
We need to welcome – without exception - the differences of every child. This means that a *culture of* mutual appreciation of *diversity* and creativity in constructing teaching arrangements has to be developed throughout the school day. In the afternoon the school-house and garden needs to be a playground where all children meet for leisure time and friendship.

We also have to lay emphasis on raising independent personalities who can also get along with others. Children learn this positive attitude towards diversity from their first school day and during every single day in school. There are many circles where classes meet and everybody recounts what he or she has been or will be doing. Children find out by themselves that *every piece of* work must be appreciated – since a child exerted much effort. As a tool you can use class-instructions like "Work with Peter!" If children are told to take care of each other and work with one another, they will do so. When they think and talk about their working processes later on, they always find positive aspects of working together.

Development is movement: Partners for a learning institution

There are lots of possibilities for parents to take part in school development. They can represent *parents' interests* in regular conferences, and they take part in different school-development-groups. Here and everywhere staff and parents meet as cooperating experts.
Sophie-Scholl-School works as a learning institution. All members meet in a process of school- development. Many different types of circles and conferences are necessary during this continual process of school development. The outside-view is an important eye-opener for hidden themes or targets, so close contact to research and evaluation is important. During the last years we therefore had research done on the following topics:

- Movement and sports during lessons and during the school day (University of Marburg, 2007)
- Inclusive teaching methods: reality or dream? (University of Gießen, Germany 2006)
  • Attitudes of children without handicap towards children with mental handicaps (University of Gießen, Germany 2005)

Sophie-Scholl-Schule was set up ten years ago to work with grades 1 – 6. After grade 6 all pupils are divided into different schools – none of them with an inclusive concept. This is a dramatic cut for most of the children, especially for those who have no choice and are put into special schools without being asked. Since Sophie-Scholl-School is a school for *all* children, we decided to extend our school up to grade 10. We worked out a concept paper and asked for permission. If we get that, we will have to find a building and new teachers: The extension of our school is the biggest challenge in the years to come!

References and contacts:

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5.9.3 Public School Padre Jerónimo, Madrid, Spain

Public School Padre Jerónimo (Algete-Spain) is an Infant and Primary public school (from 3 to 12 years old) which educates 450 students. There is an average of 30-35 students with different special educational needs: psychological, visual, physical, etc. Public School Padre Jerónimo is a good practice example showing how to develop and adapt students' materials for the classroom in order to enable all students to be *included in ordinary schools. It demonstrates how to elaborate work documents which support better coordination of school staff and more effective organization of the school.*

Strengths:

- Teacher training and development
- Changing attitudes of teachers and other staff
- Character of additional support and its organisation

The school decided to participate in the Integration Programme for Students with Special Educational Needs during the academic year 1987-88. Since then, the school has continuously revised the curriculum, updating it with strategies for students with special educational needs (SEN). These strategies involve the organization of the school staff, as well as the specific work of specialist diversity staff who deal with educational materials. Under these changes the school staff realized how their professional planning contributes to the main aims of the Inclusive School.

The School Executive considers that each school should devise its own strategies for the students' work on a general level, whilst also addressing special educational needs. There are some factors which are necessary for good practices in education.

Of primary importance in inclusive education strategies is the necessity of dialogue with as many parties in the educational community as possible. This means that communication with special needs students should involve dialogue with the school heads, the teaching staff, assistants, families and the students themselves. There should be room for individual needs, but a common philosophy should result from the dialogue between all parties concerned. This common philosophy should also be shared by all school staff members. By involving as many individuals as possible it enriches the result.

Each party should contribute to this inclusive process depending on their skills:

- The school - by providing organizational, professional and material structures;
- The educators - by planning methodologies in which the special need students are involved as well as by providing individualized activities that aid their intellectual and social development;
- The assistants and families - by being good examples of inclusion; and
- The students - by assuming the differences are an enriching aspect of diversity.

Another essential factor for developing a professional and coherent environment is the coordination of multidisciplinary team teaching each student with special needs. Once the Public School Padre Jerónimo became aware of the importance of such coordination it developed its own methods of management. At present, they plan specific meetings in which all teachers working with the same child coordinate their work. In order to simplify the coordination of the specialist teachers' work, the school has invented its own Working Sheets. The Working Sheet says how the common or modified curriculum is used and it functions as a real record of learning process of each child. The progress of different skills (for example: motor skills, language, reading, writing...) is being recorded and whether it has been achieved by the student with or without support.

The school staff consider that the practices of teaching staff should be as common in mainstream schools as possible, and this is the reason for having support staff for students with special needs in the classroom whenever possible. This could be a difficult way of working at certain levels and in certain subjects, but it favours inclusion of students with special needs and increases the personnel resources in the class. When it is not possible, the teacher creates small groups (about 3-5 children) for specific activities. Even more specialized teachers (physiotherapist and speech therapist) use both practices, using assistants and small groups.

In terms of educational material, care is taken to use the same materials as far as possible for students with and without special educational needs. If these materials are far from the student's competence, they are adapted according to individual needs.

Finally, the teachers develop activity books adapted to each student. Their activity books aim to have the same educational outcome as the rest of the students, but are adapted to individual needs.

The follow-up of the educational process is undertaken in coordinated meetings involving all staff educating students with special needs. The staff have created special evaluation reports which are updated and checked annually. These evaluation reports collect data on the practices of all those involved in the education process from the professionals to the family. When evaluating educational progress, the staff adapt the evaluation reports in order to make them more realistic according to the education level of the students but retaining the same form of evaluation for all students.

The school aims to involve the families in the most crucial moments of the education of children with special needs:

- by informing them how the school works with their children;
- by inviting them to participate in the follow-up and evaluation of the educational process of their children and;
- by providing them with proper information at the end of every school year and most crucially, at the end of the school attendance.

Public School Padre Jeronimo also promotes awareness about the school topics and any other relevant information. Doing so, the school makes the education of students with special needs not only a matter of a single family but also a matter of common interest.

By using this style of inclusive education, the benefits are far-reaching. The benefits of this education can be felt across the whole educational community, and echoes of this reverberate in society. The school strongly believes that if a child can be put in an equalised educational environment, there eventually will be a progressive social environment. This way the school not only influences the lives of students with special needs, but also affects the evolution of thinking on inclusion within social authorities and policy-making bodies.

References and contacts:

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5.9.4 Practice Centre of Pedagogical Training School Vienna, Austria

The project "Mehrstufenklasse" has been developed as an experimental example running within the public educational system. In the "Mehrstufenklasse" are 10 to 16 year old students in one class including children with disabilities. The inclusive education in that class is achieved by accepting the natural feelings and behaviour of children at their particular ages. This attitude is the most important attribute of the teachers and the students themselves in inclusive education. The primary resource is peer-learning. The children learn to reflect on their own work.

Strengths:

- Transition between different stages and forms of education
- Peer support and relationships
- Listening to young people

The project of "Mehrstufenklasse" has been successfully running at the Practice Centre of Pedagogical Training School in Vienna since 2005. This type of learning option for Secondary school students from ten to sixteen is unique in Austria. The school is placed in a district with a high percentage of students from diverse cultural backgrounds, consequently with a different mother tongue than German. One of the main principles of this school is to face the reality and implement the most ideal teaching approach in practice as well as to monitor and evaluate this process from a scientific point of view in order to ensure as large an impact as possible on the school system. The project has been accompanied by a scientific survey over the last 2 years. Professor Dr. Wilhelm is supervising this exceptional model of a "Mehrstufenklasse". Together with her, the team of teachers implements the concepts of the reform pedagogy:

- to assist and educate the students following a performance-oriented curricula;
- to supply remedial-teaching when necessary;
- to integrate and include students with different disabilities into the learning process;
- to implement a fair and valid assessment or testing system, that always views the individual student at his/her personal developmental level.

The teachers' team sees the main task in educating the young learners and facilitating their autonomous cognitive and social learning. The social maturity gained in this mixed class with all its individual learners is considered as a great success to be achieved. It requires enormous acceptance and flexibility from all participants within this learning process. It is positive for students to take more responsibility for their education. The approach of teachers has an impact on motivation and success in the classroom.

Aims of the programme:

- to supply individual remedial teaching for all the diverse learners;
- to create and build up a supportive learning atmosphere where the learning process flows as smoothly as possible;
- to foster a warm atmosphere, where the students feel not only the teachers´ interest for them but the interest and acceptance from their peers;
- to build up and enhance the learners´ self-image and their beliefs in themselves and thus help them to learn in ways that are personal and significant for them;
- to reduce a "repeat" of a school year but to guarantee safety for the individual student who can "stay" in this class for up to five years;
- to help students to improve their performance towards a successful mastery of the "Hauptschule";
- to build up a supportive environment, where the students help, assist and accept each other, and where they learn to welcome "the newcomers" and to let "the old ones" leave;
- to enhance the self-esteem and the intrinsic motivation of the individual students who can find themselves as peers and mediators in this learning atmosphere;
- to promote and demand individual learning achievements for all students: the ones with the best cognitive capabilities or the ones with lower capabilities.

Evaluation

As the team wants to reduce anxiety and stress within this learning system, marks are only given during the school year when the student wants to get them. The parents are informed regularly about the personal achievements of their children, but especially at the end of a half term. All students receive a written report with marks at the end of a school year. The last year students then receive it twice, in January and at the end of the school year.

Organisation

The class consists of 18 - 22 students, including four to five students with disabilities. At this moment, there are 7 “leavers” concluding their last year in this class. Therefore, another 6-7 younger students will be welcomed to this class. A group of 8 or 9 teachers usually work with the students. This team consists of subject teachers, five of whom obtain additional training and education, for example a Degree in reform pedagogy and Montessori, degree from sociology and mediation or diploma in special pedagogy for children with intellectual disability.

The students are enabled to learn individually and thus moving at a personal “speed” is guaranteed. The learning process is mostly arranged in topic based modules. The day is structured by the timetable of the students. At the start of any subject, and as necessary, the learning in class can also be teacher-centred, and then follows tasks that vary according to the levels of students and to different grades. Students with disabilities also get their “flow charts”, but they need more guidance by the teacher or a peer. The team of teachers design a “flow chart” that:

- enables the learners to create knowledge that is “digestible” for them in their personal developmental level;
- promotes self-organised learning where the students may choose the material that suits them the best;
- enables them to reflect upon their achievements gained at the end of the week;
- gives teachers and learners the space to communicate with each other, and to learn to cope with conflicts.

Assessing students’ learning, behaviour and their achievements

An ongoing assessment of the learners is guaranteed by the team of teachers, who exchange their insights and perceptions and seek advice either in pedagogical conferences or involve external experts. If necessary they arrange meetings with a physiotherapist, the psychologist for the school district, the medical doctor of the school or a social worker. The parents, and if necessary the head teacher, are constantly involved in the education process.

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CHAPTER 6: DISABILITY AWARENESS FOR CUSTOMER SERVICE PROFESSIONALS

The current output will be developed under WS1.1 and will start at M1 and end at M6.

As we go through our lives, we experience different things and develop particular attitudes. It is not surprising then that people will perceive the same situation differently, as a result of their life experiences. Let me give you an example, using a set of steps as the common theme.

Imagine you had spent the day at a disability awareness course. For the first time you came to realize what an obstacle steps are to a person in a wheelchair. On your way home, you climb the same set of steps as you always do, but this time you see them differently. You wonder where the ramp is, reflecting that maybe the building is inaccessible to a wheelchair user, unless they are to be carried in.

Now imagine these steps again. You've just been reading about all the things you can do to keep fit. One of these things is to use the steps rather than the lift. You get home, and see the steps. You realize they are an opportunity to help you get fit and you decide to run up them.

Here are those steps again. This time, you work at a stadium cleaning up after the crowd has been and gone. All day you are going up and down the steps, cleaning up other people's rubbish. By the time you get home you are fed up and tired. You come to the steps that take you to your house. You greet them with a groan, hardly having the energy to climb them and remembering the long day you have had.

Last week it was raining and the steps outside your house were slippery and you fell down them. You sprained your ankle and are very shaken up. You spend a few days recovering. Today you go to leave the house and are faced with the steps. You feel anxious, remembering your pain and stress. You nervously approach the steps and take them one step at a time, being careful not to slip.

With the instability in today’s world we have a reason to **fear the uncertainty** in our life. Family members lose their jobs, their homes and belonging’s. Friends and co-workers lose their jobs from the companies they unselfishly worked for loyally for years. Nonprofit organizations drastically trying to find ways to stay open to help the people who need their service, even more desperately during these unstable times. Throughout these difficulties with money, housing, lack of employment, medical problems, taking care of our elderly family members or friends, all cause stress, anxiety and fear of the unknown. This tends to put extra strain on friendships between family and friends.

Having a disability can add greater complexity into some of these difficulties. People with disabilities might face extremely significant problems with stereotypes, particularly from people who lack firsthand experience interacting with individual with disabilities. The people with disabilities are often stereotyped as socially stigmatized, as object of pity, as eternal innocents, or as sources of inspiration, both in society and in representations of society, such as literature and art.

Defining “health” as the absence of disability or chronic illness negatively affects individuals with disabilities, many individuals lead active, fulfilling lives, which include employment, parenting, sexual relationships, and community involvement. While a disability doesn’t necessarily imply illness, some disabilities may lower the threshold to secondary conditions. Preventive care and early intervention can reduce complications.

Individuals with disabilities frequently struggle to find providers who are sensitive to their needs. Health care facilities or offices may not be accessible or have the equipment needed to serve individuals with disabilities. Also, individuals can be embarrassed because their disability requires them to obtain additional assistance from staff, due to the fact they lose part of their independence and their privacy. Sometimes, staff may not know how to assist an individual with a disability, causing frustration for both of them. Many times limitations in the physical environment exist, such as the lack of appropriate equipment, may cause them to forgot procedures for individuals with disabilities that would otherwise be commonplace. As a result, individuals with disabilities may only pursue medical care for emergency or acute conditions, or they may not access other services and supports that can increase their health and quality of life. The acknowledge about disabilities and poor accessibility can pose significant barriers that prevent individuals with disabilities from receiving appropriate and effective treatment, services and supports.

Individuals with disabilities should require the same quality of medical service and preventive care as individuals without disabilities, but the former may be underserved and receive less than quality care.

Persons with disabilities are individuals first. Each person's needs and strengths are unique, and an accommodation solution that works for one person may not work for another. When accommodations for persons with disabilities are being explored, the emphasis should be on assessing and accommodating each person's unique needs and circumstances, rather than resorting to preconceptions or generalizations about persons with a particular disability.

Also, turning a person with a disability into a hero is another common social reaction. This reaction is interesting- on the surface it appears to be positive, but it is actually a different type of negative reaction. The hero reaction usually appears in the form of a compliment like "I find you so inspiring" or "I am amazed that you can do that" or something similar. These comments, though they show comprehension of the impacts of a disability, also serve to distance the person with a disability from the speaker. A disability is always there and living with it, it is not a heroic act. It is a simply one way of living. To make a person with disability a hero or an inspiration serves to distance the person with the disability from "normal" people. This is evidenced by the fact that people who view persons with disabilities as heroes may not accept any views that contradict this position, even when expressed by person with disabilities.

The largest disabled people encounter are other people because our societies have always been occupied with stereotypes and prejudice towards them. The stereotypes make people believe that the others are unable to view them as anything but the stereotype. All the perceptions, prejudices and misconceptions can lead to the development of **fear and uncertainty** for all perspectives. There is a social distance created between the "normal" people and people with disabilities leads to complete ignoring them.

In addition, a great deal of discrimination faced by persons with disabilities is underpinned by social constructs of "normality", which reinforce obstacles to integration, rather than encourage ways to ensure full participation. Discrimination against persons with disabilities may be based as much on perceptions, myths and stereotypes, as on the existence of actual, functional limitations. This is referred to as "social handicapping".

Human Rights Education

In terms of education, concerns have been raised regarding negative attitudes and stereotypes regarding persons with disabilities on the part of educators, administrators, and fellow students. These attitudes can pose a substantial barrier to persons with disabilities, as well as creating in themselves an unequal educational environment.

Specific studies on children and youth with disabilities reported that children with disabilities are less likely than other children to feel that other children like them, more likely to be bullied in school, to report that other children say mean things to them, and less likely to report that they get along well with their teachers.

There are concerns that teachers are not being provided with adequate training, information and in-class support for teaching children with disabilities, and ensuring that they are integrated into mainstream classrooms in a respectful and dignified manner. This impact, not only on the quality of the educational services children with disabilities receive, but also on their ability to become fully integrated into the classroom.

At the post-secondary level, concerns have been raised regarding training and support programs, and awareness levels among instructors. In surveys reported that most post-secondary disability service providers rated in-service training of instructors as fair, poor, or not available.

People with disabilities require the same quality and the same opportunities in education system. Deeper knowledge and understanding of disability and its consequences, better information among the society about choices of suitable schools, must be achieved in order to experience and practice the inclusion of pupils and students as the norm globally in education. Furthermore, the need for collaborative service provision is necessary in supporting students with disability. In many countries, in order for the coordination to function between education, health and community services should be more organized. Ancillary staff of the most necessary disciplines of speech therapy, occupational therapy and physiotherapy is often not easily accessible to education authorities for their students. But, the recent years the procedures for accessing these services have undergone change and accessibility started to diminish.

Your environment and interaction

In a customer-service environment, we need to be most aware of physical, sensory, psychological, behavioral and neurological disabilities.

Customer-service professionals come into contact with people of many cultures, ages and abilities and may need to adapt their skills accordingly to provide the required assistance. In Institute of Psychosocial Development we ease this uncertainty by increasing our awareness of our environment and how it may impact on our interaction with someone with a disability.

We always remember that people with disabilities have abilities, so we pay attention to our style of communication, for example we listen attentively when we are talking with a person who has difficulty speaking. We are patient and wait for the person to finish, rather than correcting or speaking for the person. Also, we never try to finish a person's sentence just because they are talking slowly or more labored than us. If it is necessary, we ask short questions that require short answers, a nod or shake of the head. We do not pretend to understand if we are having difficulty doing so. Instead, repeat what we have understood and allow the person to respond. If we are still unable to understand what the person is saying, ask if there is someone who can interpret for us or consider using alternative means of communication.

We do not assume a person cannot perform a certain task. With the right accommodations and support, a person with a disability can be very productive. Also, a person with a disability knows best what he or she needs in terms of accommodations.

In our organization keep always and office spaces clear from excess clutter that may make it difficult for people to maneuver around or reach equipment such as fax machines, copiers and printers.

In addition, we disseminate company information, announcements or events through various methods of communication such as email and flyers.

We provide accessible restrooms and telephones. If such facilities are not available, we are ready to offer alternatives, such as a private or employee restroom, a glass of water or a desk phone.

The transportation is often a major issue for those who have to depend on others for assistance in getting to and from our organization. We give to the individuals with disabilities the opportunity to be assessed in their context.

Our staff is well trained. The organization encourages fellow employees to learn how to assist persons with disabilities in cases of emergency, including proper evacuation procedures and medical emergencies.

Institute of Psychosocial Development during its experience in the field of mental and psychological health organizes seminars, workshops and many others activities in which both non disabled people and people with disabilities can participate. In the above activities, especially in workshops, we try to encourage interaction between the participants. With this reaction we try to assist the participants in interaction amongst them. Also, it helps in understanding the fears and the uncertainty that both face.

Basic tips for customer service

Following are some useful tips to improve disability awareness such that the organization has a more harmonious and motivated workforce with maximum efficiency:

- Understand that not everyone is the same. The first step towards improving disability awareness as a skill, in oneself or in others, is acceptance of the fact that every individual is unique. A culture of inclusion must be developed by showing understanding and respect towards individual differences. This will ultimately evolve into a harmonious work environment desired by every organization.
- Dig deeper to understand better. If a worker or employee is suspected of a disability, carry out enquiries for more information on his health in order to get a deeper insight of his condition. This will help you determine his strengths and weaknesses as well as the suitable work environment according to his needs so that his efficiency can be maximized. However, this entire process must be confidential with the workers/employees reassured that the personal

information obtained shall be shared, with their permission, only where required.

- Avoid making assumptions. As an employer or manager, it is imperative that you avoid stereotyping impairments and making wrongful assumptions that could cloud your judgment about someone's ability to perform well. For example, in denying a promotion to someone with a history of depression, you could be taking away from the firm one of its best future leaders.
- When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter.
- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands.
- When meeting a person who is visually impaired, verbally identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.
- If you offer assistance, wait until the offer is accepted, then listen or ask for instructions. It is very important not to make assumptions about what an individual can or cannot do without assistance.
- Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others. Also, never patronize people who use wheelchairs by patting them on the shoulder or head.
- Leaning or hanging on a person's wheelchair is similar to hanging on a person; one should view a wheelchair as part of the personal body space of the person who is using it. Therefore, as a general rule, ask yourself if you have a close enough relationship with a particular person such that you would reach out and touch that individual regardless if he or she uses a wheelchair. If the answer is yes, then it might be more appropriate to lean or hang on the person's wheelchair.
- When speaking with a person who uses a wheelchair or crutches, place yourself at eye level in front of the person to facilitate the conversation.
- When trying to get the attention of a person who is deaf, tap the individual on the shoulder or wave your hand. Look directly at the person and speak clearly in a normal, non-exaggerated way. Some people may read lips, however lip-

reading is only 30–50 percent effective. For those who do lip-read, be sensitive to their needs by placing yourself so that you face the light source and by keeping your hands away from your mouth when speaking. Not all people who are deaf or hard of hearing are able to lip-read, in which case an interpreter may be present or you may need to consider alternative forms of communication such as demonstrative or written.

- Ask people with disabilities what terminology they prefer; not all people with disabilities use the same words to describe themselves and their disabilities.
- Do not use "normal" to describe someone who does not have a disability, implying that someone with a disability is not normal. Say that the person is "non-disabled."
- Do not interact with a service dog while it is working.
- If you encounter a person having a seizure, do not try to put anything in his/her mouth. Do not give him/her something to drink and do not attempt to restrain his/her movements.
- Review your interactions with others and ask yourself the following questions:
  How do I interact with customers (body language and speech)? How can I improve?
  How will customers need to interact with me?
  What are the considerations I need to make about my environment?

- Above all, do not be afraid to ask questions when you are unsure of what to do!

The list of the tips can be endless. At every case, we have to assess the context in which every individual needs to interact. Every organization could adjust its facilities in order to include disability and non disability population in an effort to raise the disability awareness.

Good practice

Good practice Title	Psychological and Intelligence Assessment Integration
Country	Greece

Type of practice*	Measure
Included target groups	Children and adolescents with physical (somatic/kinetic) disability and severe behavioral/emotional/psychiatric issues
Requirements	Psychometric tools, Specialized psychologists, Individuals that cannot be transferred
Description of practice	The institute of Psychosocial Development has services like psychological and intelligence assessment. The assessment in a clinical framework is an important part of the overall diagnostic procedure combined with the medical history of the patient. It doesn't substitute the psychiatrically diagnosis, but it is a thorough investigation of individual psychological functions (mental, emotional, social, and interpersonal). This process highlights not only the dysfunctional but also the healthy aspects of personality, since the personality as a complex concept can be expressed in various ways. The evaluation includes battery tests. Each individual test provides different information about the person's personality and contributes to its comprehensive description. In this way, a comprehensive diagnostic assessment of the person is formed, which leads to more accurate therapeutic options. The Psychological and Intelligence Assessment is provided by specialized psychologists, certified in the use of psychometric tools. The certificate is granted and accepted by public and private entities. In the perspective of disability awareness the institute enables individuals with disabilities (not only kinetic, emotional and behavioral too) to be assessed in their context (clinic, home, institution). Often, people facing difficulties are difficult to be transferred in the building of the Institute because there are obstacles like: • It is difficult for the person to leave the house.

	• It is difficult for the person to be transferred because the Institute is at the city center (Larissa is not a friendly city for people with difficulties).
Benefits for target group	The Institute decided to provide the ability for persons that are in a difficult situation to be assessed and not to lose the possibility to be assessed because of their difficulties. In Greece in order to preserve their welfare payments it is essential to be assessed recurrently.
Source of funding	Self-funded
Additional comments	It is a fruitful experience and we observed that once we started to conduct the assessment in the context of the individuals with disabilities, the requests for assessment has been raised significantly.

Recommendations

Increase public awareness and understanding of disability

Therefore it is vital to improve public understanding of disability, confront negative perceptions, and represent disability fairly. Also, mutual respect and understanding contribute to an inclusive society. For example, education authorities should ensure that schools are inclusive and have an ethos of valuing diversity. Employers should be encouraged to accept their responsibilities towards staff with disabilities.

Collecting information on knowledge, beliefs and attitudes about disability can help identify gaps in public understanding that can be bridged through education and public information. Governments, voluntary organizations, and professional associations should consider running social marketing campaigns that change attitudes on stigmatized issues such as mental illness. Involving the media is vital to the success of these campaigns and to ensuring the dissemination of positive stories about persons with disabilities and their families.

Conclusions

There are more than one billion people with physical and mental disabilities in the world who must overcome challenges every day. One of those challenges is encountering other people. As a society, we are all different and must recognize the importance of acceptance.

Disability awareness is very important when it comes to breaking stereotypes and overcoming preconceptions regarding disabilities. Disability Awareness means to educate people about disabilities, but also provide them with the knowledge on how to carry out tasks regarding disabilities. People can learn about disability awareness through classes, training courses, or even from disabled people. Learning acceptance is important but employers, businesses, and organizations must also understand that people with disabilities must have the same quality in health, education and employment system.

Fortunately, there are many people interested in getting involved with disability awareness and often wonder how they can take part in making a change.

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