DACTIVE

disability and active citizenship

Training course for educationalists in practical interventions addressed at persons with intellectual disabilities for developing competences of active citizenship

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INTRODUCTION

This handbook is the result of cooperation between 7 European countries (Austria, France, Germany, Greece, Italy, Romania and Spain) and the outcome of the D-ACTIVE (Disability and Active Citizenship)project. The background to the project can be summarized as follows: Surveys carried out over the last decade by the European Union (EU) and the World Health Organization (WHO) on the wellbeingof people with disabilities and their families have shown that this area of the population still runs a high risk of social exclusionthroughout Europe. Hardly any improvement has been made regarding their situation,as far as participation and active citizenship are concerned (cf. European Disability Forum, Leonardi et al. 2009, Council of the European Union 2009). The project's aims are therefore as follows:

- to develop innovative learning approaches in order to foster the inclusion of marginalised and disadvantaged people (with intellectual disabilities) into society and the labour market
- to develop systems that allow for sharing qualityprocedures,with a view to educatingvulnerable people
- to promote learning opportunities based on participation in activities rooted in local communities

In short, the project is all about improving the quality of life of disabled people and their families (caregivers). In order to make such a difficult parameter as *quality of life* measurable as well as comparable, at least to some extent, and to determine factors that influence it, the International Classification of Functioning, Disability and Health (ICF) (2001) serves as a useful tool.

Before discussing the ICF in more detail, it is necessary to provide the reader with some general background information. There are two different ways of describing disability - the medical and the social model. Whereas, according to the first model, disability is simply a personal feature that can,to some extent, be corrected by professional intervention, the second model describes disability as a social phenomenon. From this point of view,a person's environment is held responsible for his/her disability (which is therefore not an individual attribute at all). According to WHO, neither the medical nor the social model is sufficient when describing what the term "disability" actually means. That is why a *biopsychosocial model of disability* (a combination of the aforementioned models) was promoted. This biopsychosocial model serves as the basis of the ICF. All in all, the ICF provides a coherent view of the different perspectives of health: biological, individual and social (cf. WHO 2002: 8f.). For this reason, the ICF can also be regarded as a social classification. Furthermore, it incorporates the *Standard Rules on the Equalization of Opportunities for People with Disabilities* and has already been useful as an educational tool,

by raising awareness of the multifaceted nature of disability (cf. WHO 2001: 4-6), which makes it even more useful to the project.
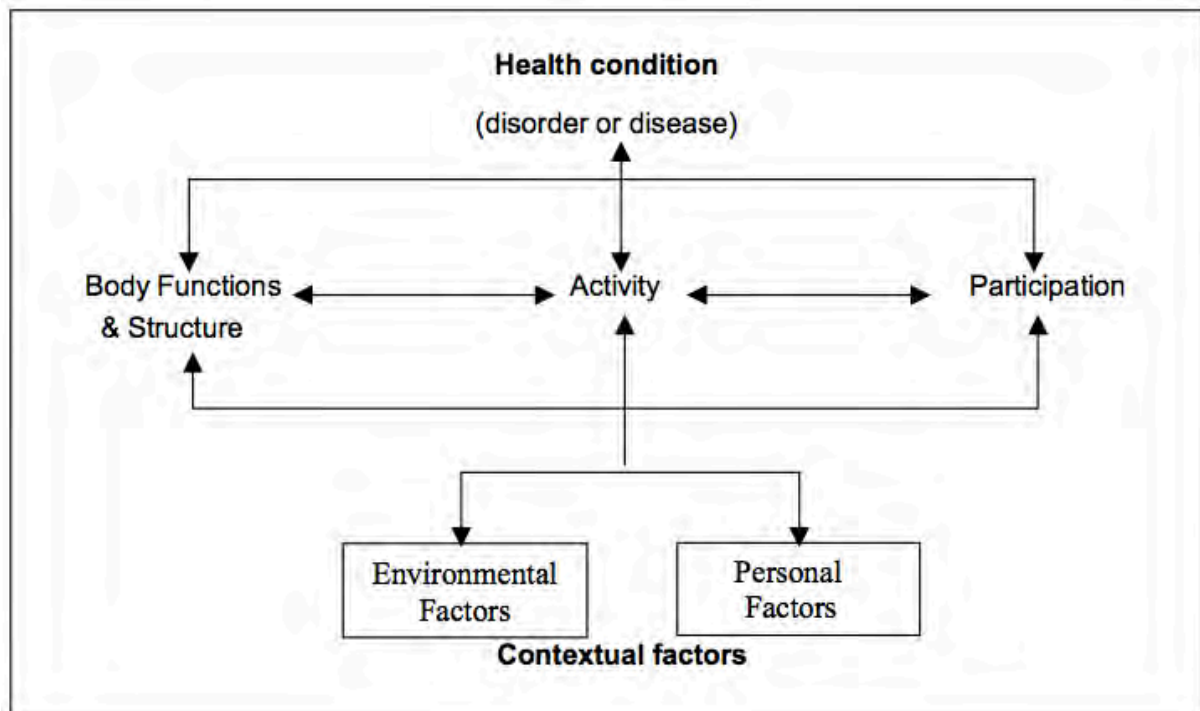
Figure 1: ICF's model of disability (WHO 2002: 9)

As shown in the figure above, an individual's activity can be defined as theinteraction betweenvariouselements, such as health-related or contextual factors. For a better understanding of the overall meaning of the figure, it is necessary to define the terms used:

Body functions are the physiological functions of body systems (including psychological functions).

Body structures are anatomical parts of the body, such as organs, limbs and their components.

Impairments are problems in the body function or structure, such as a significant deviation or loss.

Activity is the execution of a task or action by an individual. Participation is involvement in a life situation.

Activity limitations are difficulties an individual may have in executing activities.

Participation restrictions are problems an individual may experience in involvement in life situations.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives" (WHO 2001: 10).

To sum up this short excursus on the ICF, we think a final overview of the ICF and its structure might be useful.

	Part 1: Functioning and Disability		Part 2: Contextual Factors	
Components	Body Functions and Structures	Activities and Participation	Environmental Factors	Personal Factors
Domains	Body functions Body structures	Life areas (tasks, actions)	External influences on functioning and disability	Internal influences on functioning and disability
Constructs	Change in body functions (physiological) Change in body structures (anatomical)	Capacity Executing tasks in a standard environment Performance Executing tasks in the current environment	Facilitating or hindering impact of features of the physical, social, and attitudinal world	Impact of attributes of the person
Positive aspect	Functional and structural integrity	Activities Participation	Facilitators	not applicable
	Functioning			
Negative aspect	Impairment	Activity limitation Participation restriction	Barriers / hindrances	not applicable
	Disability			

Figure 2: Overview ICF (WHO 2001: 11)

As mentioned above, the purpose of the D-Active' project is to improve the quality of life of disabled people, as well as that of their families. From the point of view of the project, the quality of life is strongly connected to an individual's activity and participation.

In addition to the ICF, an additional factor that influences the project is the European Union. In 2006 the European Parliament and the Council published the *Recommendation on Key Competences on Lifelong Learning*. Therein key competences are defined:

> "as a combination of knowledge, skills and attitudes appropriate to the context [i.e. globalization, new challenges, different needs of learners]. Key competences are those which all individuals need for personal fulfilment and development, active citizenship [sic!], social inclusion and employment" (2006/962/EC).

There are eight key competences: communication in the mother tongue; communication in foreign languages; mathematical competence and basic competences in science and

technology; digital competence; learning to learn; social and civic competences; sense of initiative and entrepreneurship; and cultural awareness and expression (cf. ibid.). As quoted above, these competences are prerequisites for active citizenship and social inclusion. Hence, D-Active focuses onmaximizing development of thesekey competences in disabled people.

The question of how activity and participation are defined (in the ICF – being the basis of the present project) has already been answered. Nevertheless, the above-mentioned opinion on the quality of life raises further questions: Which domains included in the ICF are relevant to activity and participation? Which skills does a person require, in order to be able to participate and be active? How can the development of key competences be incorporated when working with disabled people? How can these skills and competences be assessed? Acknowledging the fact that no man is an island – how can the different environments of a person be involvedsufficiently? How can professionals from different fields collaborate efficiently? - Answering these questions is the aim of the 5 units that comprise the handbook. The handbook per se is intended to serve as a basis for a model course, aimed at educationalists working with disabled people. By taking part in the course (30 hours/6 hours per unit), educationalists are trained to foster active citizenship in people with disabilities.

Unit 1 is the contribution of the Spanish project partners. It deals with the methodstouse to foster physical, psychological and social well-being of people with disabilities. In the second unit,the partners from Italy (Co&So) provide the reader withmodels for the development of specific and key competences (defined by the European Council) in the project's target group. Unit 3 (written by the Italian partners from Co&So) identifies measurable indicators, selects verification methods, evaluation methods and competence certification for people with intellectual disabilities.Models regarding how to deal with parents, as well as with the social and working environment of the target group, are then discussed in Unit 4,provided by the Romanian partners. The fifth and final unit (Italy, Regione Veneto) deals with, how to collaborate with professionals from different fields. Additionally, attention is drawn to the development of assessment tools and their integration in already existing models.In addition to coordinating the handbook's development, the Austrian partners contributed to the introduction and the conclusion. The handbook also features an appendix that offers a list of recommended further reading (in different languages) and definitions of relevant ICF domains.

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UNIT 1   Models for fostering physical, psychological and social well-being in people with disabilities

Partner 7 – Spain

1. Aims of the unit

The International Classification of Functioning, Disability and Health (ICF) establishes anoverview of people with disabilities, focused on their capacities and limitations in everyday life. Based on the aforementioned view, several basic concepts are defined. Professionals who provide services aimed at people with mental disabilities can benefit from using these concepts. In the following, the reader will be provided with an introductory unit on the ideology underlying the ICF, and subsequently with details concerningeveryday activities, which are put forward in the ICF manual.

This unit does not aim to explain the whole ICF diagnosis and codification methodology. On the contrary, it only focuses on the image of humanity underlying the manual itself.

For this reason, this unit is divided into two parts:
   a) the ICF's view of disability
   b) the ICF's domains relevant to activity and participation

2. ICF's view of disability

2.1. General aims

- To gain insight into the disability model proposed by the ICF; ICF's view of disability.
- To work on the basic areas of this unit: concepts of health, work, disability, activity and its limitations, participation and its limitations; analysis of everyday activities.
- To analyse the influence of the environment on the development of operations.
- To discuss the necessary technical needs of individuals (products and technologies).

2.2. Example(s) of best practice

Currently, our organization is developing a training course on the ICF and its view of disability. This allows us to develop a new model of operation based on the person, focusing on his/her aims and interests. This model is called *Personal Project*.

2.3. Didactics and exercises

1. Analysis of the practices carried out in our centres.
2. Discussion of the model and the plan of operation currently developed and its adaptation to ICF ideology.
3. Investigation of how to include training foreveryday activities in our daily care work.
4. Role play ('a day in a wheelchair', 'Today I am the care receiver', …) to fully understand how disability influences everyday activities.

3. ICF domains of particular relevance to activity and participation

3.1. Mental functions

3.1.1. General aims

- To raise awareness among professionals of the differences in cognitive development of people with intellectual disabilities (IDs).
- To gain in-depth knowledge about the support needs of people with IDs regarding skills related to conscience, orientation (time, place, person); intellectual skills; energy and drive functions; sleep; concentration; memory; emotional functions; perceptive functions; higher cognitive level functions and language.
- To gain in-depth knowledge of the ageing process of people with IDs.

3.1.2. Didactics and exercises

- Discussion of the main neuropsychological and cognitive impairment test tools.
- Reading and discussion of the texts related to the topics at hand.
- Analysis of case studies and videos.
- Role-play activities to explore how people with IDs express their emotions.
- Discussion of appropriate learning methods for people with IDs, regarding the topics at hand (cognitive functions, handling emotions and cognitive impairment).

3.1.3. Example(s) of best practice

As part of the on-going service in Spain, diagnostic tests are carried out on a regular basis, to detect cognitive deterioration in people (older than 42) with IDs. The aim is to spot possible signs of premature ageing and adapt programs to meet individual support needs.

3.2. General learning and communication tasks

3.2.1. General aims
- The human learning process: theoretical input and practical examples.
- Understanding of the learning process in people with IDs (special needs, adequate inputs and materials etc.)
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- Understanding of the learning process in people with disabilities, in order to develop skills regarding the special teaching/training methods needed.
- The gain of in-depth knowledge of skills, such as the ability to understand and express information, through symbolic or non-symbolic behaviour.

3.2.2. Didactics and exercises
- Discussing learning problems observed in people with ID.
- Deciding which skills should be improved – training skills relevant to everyday life.
- Reflecting on, designing and practicing with materials, supporting independent activity management (use of calendars, pictograms, etc.).

3.2.3. Example(s) of best practice
The client uses the course materials and his/her own skills to manage the activities to be carried out.

Example: Keeping a calendar: In order to be able to manage in everyday life and successfully carry out the tasks encountered, it is useful/helpful for some clients to keep a calendar, which helps them structure their day/week/month. Depending on individual disability,it may be necessary to use pictures instead of text.

If, for example, a client is in charge of watering the plants in the greenhouse every Wednesday, this task should be written down on the calendar. Depending on the person's individual abilities, the written information may range from just the task to the whole process of carrying out the task (watering the plants: get the watering can – fill it with water etc.).

The staff should provide the clients with the aprropriate materials (calendars, templates, pictograms and sequences) so that they can manage their work/task as independently as possible.

3.3. Mobility, self-care and domestic life

3.3.1. General aims
- The gain of in-depth knowledge of the skills needed by the person with ID, in order to develop an independent life in his/her home and community environment.
- Analysis and planning of the necessary support, for development of the required skills to carry out basic key activities in everyday life.
- Becoming familiar with the tools for assessing the skills of a person with ID (analysis of their abilities and limitations) and the development of a support scheme that meets their needs.
- Learning to design programs, involving the services that encourage people with ID to participate in community life.

3.3.2. Didactics and exercises
- Reflection on how these issues are dealt with in the respectivecountries.
- Provision of incentives for activities in the various areas.
- Application of the learning methods, elaborated/discussed in the previous chapters.
- Analysis of the abilities and limitations of a person with ID and of the support system, s/he needs to be able to live independently.
- Self-care.

3.3.3. Example(s) of best practice
The centre will run workshops and/or programmes,so that people with IDs can improve the skills needed for an independent life. In order to do this, the staff at the centre will develop spaces and programmes to suit the characteristics of people with ID. The sessions will address skills such as personal hygiene, using the toilet, handling cutlery at mealtimes, physical appearance (clothing), using money, using public transport, community resources, etc.

3.4. Interpersonal relations

3.4.1. General aims
- The gain of in-depth knowledge of programmes,for the development of special social skills,in people with IDs.
- Learning about the various programmes connected with emotional and socio-affective education.
- Learning how to develop social skills (role-playing, dramatization, etc.).

3.4.2. Didactics and exercises

- Group discussion, to share ideas or already acquired knowledge about social skills in people with IDs.
- Study and review of social skills programmes, currently available on the market.
- Listing social skills, in order to visualise acceptable (worth cultivating) social behaviour, as opposed to unacceptable behaviour.
- Discussing the question: what is competent social behaviour?
- Gain of in-depth knowledge of tools, for the assessment of social relations of individuals or within groups (sociograms, relationship maps, etc.).

3.4.3. Example(s) of best practice

Besides the actual improvement of social skills, it is always very useful to give people feedback on their behaviour in everyday situations. Reflecting on difficult situations (conflicts,…) with a member of staff can also trigger learning effects in people with IDs. Furthermore, the carer must always be aware of the fact that s/he constantly serves as a role model. Thus, reflecting on his/her own behaviour is of utmost importance too.

3.5. Products and technology

3.5.1. General aims

- The gain of in-depth knowledge on the use of products and technology, by people with IDs, in various areas of their daily lives.
- Identification of factors that improve accessibility to different environments for people with IDs and foster their quality of life.

3.5.2. Didactics and exercises

- Gather information on the tools used by people with IDs and try them out yourself (i.e. wheelchairs, use of hoists, acoustic alarms, communication boards, etc.).
- Think of obstacles that might be encountered by people with IDs in everyday life (stairs, pedestrian lights without acoustic signal) written, and come up with solutions.

3.5.3. Example(s) of best practice

For a person with ID to live an independent life,it is a pre-requisite that s/he can live in his/her own home, either alone, with a partner, or with other people. One major technical aidused in IVADIS is the Personal Emergency Response service. This means that while the person is at home, s/he is connected to a support system that can respond in case of an emergency. This support service handles his/her urgent need(s) - even making a home visit if necessary, or sending medical help.

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UNIT 2   Models for developing specific and key competences
Partner 1 (Co&So/IT)
Partner 4 (CG94/FR)

1. Aims of this unit

The aim of this unit is to provide educationalists with essential information necessary for planning specific actions designed to support the development of competences in people with mainly intellectual disabilities,within the framework of what the European Council defines as *Key Competences*. At the end of the unit, the following competences should be developed by educationalists in their work with disabled people:

- Knowledge of the type and importance of the key competences, regarding development of the right to exercise Active Citizenship, on the part of people with disabilities.
- Ability to use know-how regarding the recommendations of the European Council, with a view to directingactivitiesdesigned to develop the skills ofdisabled people.
- Ability to develop training activities (with the support of experts)in which flexible and adequate methodologies and modalities are used, while working with the target group.
- Ability to participate in the development of a training course that addressesthe target group and is useful for supporting the practice of Active Citizenship.
- Ability to plan his/her own operations, taking into consideration the familiar and social background of disabled people.

2. Contents of the unit

The unit's contents focus on the following issues:

- The key competences and their importance with regard to exercising the right to active citizenship.
- Essential indicators to be considered when planning actions and operations focused on the development of competences in people with disabilities.
- The importance of the familiar and social backgrounds when designing activities aimed at developing competences.

The section that follows is a brief description of the contents that might be completed by trainers, with the help of the texts indicated in the bibliography and other useful sources.

2.1 The key competences and their importance for practicing active citizenship

The general framework of the systems and instruments suggested by the European Council, will be the focus of the next unit (unit 3) of this handbook. The unit in question will deal with what is called *Key Competences*. Key Competences are those thatin the future, according to the European Council, should form the basis of all European Educational and Training Systems, in all member states. They serve as the basis for further learning, as well as working life, and are therefore prerequisites for the development of specific and technical competences. According to the Council "Europe's citizens acquire the key competences needed to enable them to adapt flexibly to changes which may occur in Europe". The key competences "necessary for personal fulfillment, active citizenship, social cohesion and employability in a knowledge society"identified by the Council are as follows:

1) Communication in the mother tongue;

2) Communication in foreign languages;

3) Mathematical competence and basiccompetences in science and technology;

4) Digital competence;

5) Learning to learn;

6) Social and civic competences;

7) Sense of initiative and entrepreneurship;

8) Cultural awareness and expression

These competences overlap and interlock: aspects essential to one domain support competence in another, and certain aspects must be considered when planning training courses aimed at their development, such as "critical thinking, creativity, initiative, problem-solving, risk assessment, decision-taking, and constructive management of feelings".

As regards the development of the above mentioned competences in people with intellectual disabilities, the following is of fundamental importance: the European Council acknowledges the fact that there are many people with diverse individual competences, and points out that "the differing needs of learners should be met by ensuring equality and access for those groups who, due to educational disadvantages caused by personal, social, cultural or economic circumstances, need particular support to fulfill their educational potential". However, given the fact that the development of key competences requires great cognitive potential, one has to admit that our target group (people with IDs) faces limits in developing key competences. Consequently, there is, of course, a limit to their ability to practice active citizenship and to take new opportunities in specialized and technical training. Nevertheless, this must not be interpreted as a barrier in our context; on the contrary, it implies an educational mission.

We think that educationalists, who represent the target group of this course, should have a profound knowledge of the Key Competences, as they are represented in the attachment to

Recommendation of the European Parliament and of the Council of 18 December 2006 on key competences for lifelong learning (2006/962/EC).

Furthermore, with regard to trainers, we recommend the use of this document to explain the above-mentioned key competences.

2.2 Essential indications for planningoperations aimed at developing competences in people with intellectual disabilities

In order to plan learning operations aimed at developing competences in disadvantaged people, it is necessary to consider various important aspects:

- It might be useful to know that people, especially young people in the process of turning into adults, do not develop in the same way, in the different areas of competences
- Uniform teaching programs are usually important for trainers, not for pupils
- People with intellectual disabilities are often in conditions that derive from the so-called stages of evolutionary development (they are often in teen or pre-teen mental age)
- In this case, like in most cases, we know what goals pupils have to reach (in our case, the acquisition of key competences that are the same for everyone), but we do not always know at which stage they begin doing so.

Regarding the first point, it is very important to consider that people develop in different ways, in different areas of competences. For instance, one child may develop skills associated with comprehension and the use of verbal language earlier than another, due to his/her personality and context, but s/he may be retarded in terms of manual or practical skills, or vice versa. A child might be more familiar with codifying and using images, butmightencounter difficultywhen using and codifying the verbal channel. The training programs of education systems are generally based on standard models, that are not very flexible and do not take into account individual development paths at all. That is why people who do not match the standards often have significant difficulties in fitting into a program. This can be true for those, who learn more slowly or more quickly, as we commonly say, than the expected standard. Both situations can often lead to other phenomena. For instance, it happens quite often that the student does not follow the lesson, is bored or starts to disturb the rest of the group and has problems being included. As mentioned before, when approaching a group of students, we often know what goals they have to reach, but we do not know at which stage each person will do so. They probably have different levels of competences and they prefer using different channels of communication as well. The need to unify educational programs is often helpful to trainers, but not to students. We think it is more important to base the training on areas of competence that students probably have, and on languages that they can understand using channels,and that are familiar to them, in order to introduce different types of language or approach later on, when they have already understood the concepts.

For these reasons, and according to the Recommendations of the European Council (as indicated in unit 3), the following issues are important when developing training courses for people with disabilities:

- Creating a format with standard features that provides flexibility regarding methodologies, channels, and when to introduce different training contents
- Evaluating student competences at the beginning of the course (or, better still, drawing up their individual profiles)
- Providing enough time and space to adapt the format to individual needs, identified during the initial evaluation
- Providing methodologies and techniques that favor the inclusion of simulation games, reproduction and construction of settings, and that trigger different channels of communication (not only verbal)
- Introducing settingsand simulation games that refer to the future and to the possible consequences, derived from the use of skills, so that disabled students can grow accustomed to activating their competences in a flexible way
- Using concrete examples taken from or connected to the trainees' lives (focusing on things they might already know and skills they might already have)
- Providing time for evaluation of the competences at the end of the course (evaluation of the training impact and of the difference between skill levels at the beginning and at the end of the course)
- Providing, if possible, support systems and strategies throughout each changing phase (support groups for students, time dedicated to informing the families or caregivers of those involved).

We think that these are aspects thateducationalists and trainers in general should consider when planning training courses for people with disabilities. In this case in particular (speaking of the development of key competences),educationalists could be supported in the creation of flexible course settings, by providing them with different learning approaches.Educationalists should be trained in the creation ofscenarios and simulation games, and in the use of games, films, images as well as pictures - all influenced by the students' individual needs. Theoretical input should be given after the concrete examples. We also suggest that, the teachers of this module use the materials and methods, to let educationalists themselves experience simulation games and scenarios, related to key competencies.

Furthermore, it is important to keep in mind that, when developing a course addressed to people with disabilities, we have to treat the group as an instrument and an element to work with, and not as an obstacle to the learning process. Educationalists have to be trained to use inner group dynamics and to organize the work in subgroups, in order to stimulate students to help each other. If a student were, for example, more familiar with the verbal

channel (related to the key competence of communication in the mother tongue, but not necessarily to the reading comprehension) than his/her colleagues,s/he would actually have to 'wait for' the fellow students. In this case, the teacher could easily make him/her his/her assistant, when work is done in subgroups. Hence, by helping the others,s/he can strengthen his/her skills, develop creativity, sense of entrepreneurship, ability to organize his/her work, and s/he could learn how to learn.

As we have already outlined, it is very important to link the contents of the training courses to daily life experiences of people with disabilities, in order to enable them to understand the positive effects that, taking part in the course and acquiring specific competences,could have on their future lives. How can the acquisition of civic competences, for instance, influence their lives, their system of relationships within the family, their possibilities to participate in the life of the community? In this context, it is important to consider that,although people are actually willing and motivated to integrate themselves into society, a lot of them, but especially people with intellectual disabilities, show a high resistance to changes - also because of the fear of a possible increase in competences. The lives of people with intellectual disabilities are often quite fixed, regarding their relations, their approach to the community and their work. Additionally, people with disabilities are likely to not have a very clear vision of their future, and it is usually very difficult for them,to imagine themselves in the future and try to anticipate what it means to acquire new competences, to have new possibilities and to eventually evolve from a passive person in need of help, to an active member of the community. The relationship with caregivers, for example, can be subject to substantial change. After having taken part in a training course, people evolve and change patterns, that have been the same for a long time. Unfortunately, very often these changes do not last forever. People tend to fall back into their old patterns of living, and all the efforts they made in the past are then without avail. That is exactly why, it can be useful to create simulation games, that take into consideration these aspects, and help people to activate or reactivate their capacity to imagine themselves in the future, and to create flexible perspectives,also based on the change of their position in groups they are connected to.

Concerning the evaluation of a participant's initial competences or the drawing up of a personal profile, we would like to refer to the following unit (unit 3). In order to identify the areas of competences necessary, it might be helpful to make use of the ICF, which was used in the research evaluation, and considers important areas connected to the key competences.

2.3 Relevance of the social and familial context

The relationship between parents and their children (or between caregivers and care receivers in general) is characterized by a constant process of detachment from their

parents, on part of the children. Over time, peer groups and relationships with the outer world become more and more important, and an active involvement in the community takes place. The child becomes autonomous. This is very likely to be different when dealing with the relationship between parents and a child with disabilities. The process of detachment can take much longer or stop at an earlier stage. Therefore, the perspectives of becoming autonomous, often seem limited for people with disabilities, affecting different areas of life such as employment, independent living, and establishing relations.

Since people with intellectual disabilities never reach the mental age of an adult, due to their kind of disability, some parents have problems with acknowledging the fact that their children actually are adults at a certain age, just like every other child/teenager. Therefore, some adults with intellectual disabilities stay their parents' 'eternal child', so to say. Consequently, some parents have problems with imagining their children's future without them, because they think their child will always need them, just like an actual child does. Due to this fact, adults with disabilities do not get the chance to become autonomous,because their parents cannot release them. Their relationship is characterized by fixed patterns, that have developed over years and years, and are therefore very resistant to change and development.

Regarding the training course for people with disabilities, the aforementioned means the following: The involvement of family members (caregivers in general) is of the utmost importance! Not only the person with disability has to learn how to handle his/her newly gained autonomy, but also his/her parents do.

3. Didactics and exercises

Considering that the contents of the present unit should be taught, mainly by using methodologies, that include the active involvement of the participants, and that they are asked to make use of their ability to work autonomously and react flexibly, we suggest the following exercises:

Educationalists are invited to design a game or an exercise, to target social and civic skills of people with disabilities – exercising their right to vote, for example. The participants could be divided into groups and each group could be asked to suggest an exercise, including a simulation game or a series of simulation games to be done with disabled people.The groups can then present their ideas by doing role-plays, with some participants being the 'educationalist trainer' and others being the 'group of participants'.

Project work could be done as well. Trainers could do research in the area in question, together with the trainees (people with intellectual disabilities) aimed at answering the following questions: What does it mean to be a European citizen? What are my rights and my obligations as a European citizen? What does the European Parliament do? Can I vote for the candidate? What is the European Council? Where can I find information? What does my

country do in Europe or what does it try to promote? How can I put pressure on the Parliament or on the European Council? What would I like to say to the Parliament representatives?

Each of those questions could be performed in a short role-play. For example, the following scene could be laid out: A person goes to a public office to inquire information. Beforehand, the participants have to think about how the task could actually be carried out. They can prepare what to say, and come up with a list of questions to ask.

Another exercise addressed to the target group could be, doing research online in general and on official websites.

When thinking of possible exercises, educationalists should always bear in mind the information they have concerning the target group, coming from the research that has been carried out in an earlier stage of the project (questionnaires and interviews with 20 disabled people and their caregivers in each partner country; cf. unit 3).

4. Example(s) of best practice

Due to the experiences we have made with a project called *Humus,* it can definitely serve as an example of best practice. *Humus* was a training course designed for disabled people,aimed at the development of competences needed, in order to practice active citizenship. It was funded by the Province of Florence and the European Social Fund, and managed by the Social Cooperative Matrix.The training course included meetings, in which the single participants or the whole group were provided with information, and the family members of the participants were addressed, too. There were also monitoring meetings. Furthermore, there was a close cooperation with the trainers, focusing on a course design, including mostly practical methodologies, such as exercises and simulation games.

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UNIT 3 — Identification of measurable indicators, selection of verification methods, evaluation methods and competence certification for people with intellectual disabilities

Partner 1 – Italy (Co&So)

1. Aims of the unit

To provide educators with essential information, so that they can understand the principles of the systems of assessment and certifications ofcompetence,to apply to disabled people in particular,and use them when teaching a course for people with intellectual disabilities. At the end of the course, the competences, which educators should have developed, are the following:

- Knowledge of the importance of the assessment of the competences, and ability to use such knowledge to plan interventions with people with disabilities.
- Ability to use the European Council recommendations, to identify the assessment methods of the competences, which are appropriate to their work.
- Ability to apply, with the support of specialists, methods and systems aimed at evaluating the competences of people with mainly intellectual disabilities.
- Ability to participate in the development of a course, addressed to people with disabilities and aimed at developing competences, useful for the exercise of active citizenship.
- Awareness of the problems and difficulties, which arise from the process ofassessment of the competences inpeople with disabilities, and ability to find possible solutions.

2. Contents of the unit

The unit's contents focus on the following issues:

- Importance of the learning assessment and certification of competences, according to the European Council.
- Problems in the assessment of competencesin people, with mainly intellectual disabilities.
- Opportunities offered by the integration of systems, from the clinical, social and training fields.
- Development of systems and tests aimed at the assessment of competences.

Below is a brief description of the possible contents, the teacher could integrate with the help of the books cited in the bibliography or other useful readings.

2.1 The importance of the process of learning assessment and competence certification according to the European Council

During the Conference held in Lisbon, the European Council identified some problems concerning the systems oftraining of the Member States and tried to provide solutions.

The problems discussed were synthetically referring to the following aspects:

- Training systems in the different countries are based on criteria and principles not easily comparable. This aspect, according to the Council, limits individuals' mobility among countries.
- Training systems seemnot to be sufficiently interconnected with the world of work, and this is a limitation for individuals, to make the transition from the training system to the working field.
- Training and assessment of competences do not seem to acknowledge the importance of experiences gained by individuals, in non-formal and informal contexts.

In order to target these needs, some recommendations have been provided and some reference systems (frameworks and tools) identified, to be used in different countries, specifically: European Qualifications Framework (EQF), European Credit System For VET (ECVET), Europass, European Quality Assurance Reference Framework for VET (EQARF).

The EQF proposal is based on the following main aspects:

- Proposal of a common language, among the different countries to describe competences, in terms of the learning outcomes (regardless of the learning context).
- Definition of 8 levels of learning outcomes, each one defined by factors, that refer to the type of knowledge, abilities, grade of autonomy, discretion and responsibility of the person, in making use of the acquired competences.
- Definition of a set of principles to share, in the context of competence development (quality of training process) and in the process of recognition and validation of competences,generally required (in informal and non-formal contexts alike); also referring to the acquisition of key competences.
- Definition of a set of tools (EUROPASS; ECVET mentioned above).

The above-mentioned framework and tools have been conceived, to increase transparency and comparability, among the systems of training in different countries. In particular, EQF can be defined as a meta-framework on which qualifications earned in all countries can be reformulated and equated.

The system' s basic unitis a competence, that can be defined, in this context, as *the ability of the individual, to integrate knowledge and skills, in order to develop a performance*.Every country was invited to build its own training system within this meta-framework and fundamentals, but the Council allowed freedom with respect of the application rule.

Systems for assessment should be designed in order to determine, in a credible and authoritative manner, what skills the individual has been able to develop at the end of the training process.

The aspects dealt with above provide essential information for our work:

- the assessment system must take into account the definition of competence, as indicated above;
- such a system should not only evaluate the knowledge, but everything the individual is able to do, at the end of the training/education process;
- it should include new practices,with regardsto what the individual should be able to perform, at the end of the training/education process.

In the attachment to the *Recommendation of the European Parliament and of the Council of 18 December 2006 on key competences for lifelong learning,*the Council identifies the fundamental competences to all training systems. They are essential for the individual to exercise his/her right to active citizenship and are presented as follows: "Competences are defined as a combination of knowledge, skills and attitudes appropriate to the context. Key competences are those which all individuals need for personal fulfilment and development, active citizenship, social inclusion and employment."

The coursesfor people with mainly intellectual disabilities, which the project partners are going to hold in the subsequent stages of the project, should focus on such competences.

2.2 Problems in competence assessment of people with mainly intellectual disabilities

The mentioned systems have been built on the basis of needs, which, according to the Council, highlighted the training limitations and education processes, related to the population in general.They become even more evidentin people with disabilities. The risk of exclusion from the community and the labour market is surely higher in this target group,than in other groups.Therefore,it isnecessary to create more links, not only between the training system and the working field, but also among the target group and the social, clinical and educational interventionsystems.

An aspect, which is necessary to focus on, during the evaluation process, is the ability of the individual not only to produce performances, but also to reproduce them, in different contexts.

People with this kind of disabilities are often taughtin protected contexts or training courses, with the support of special assistance. The question is: Are they able to reproduce their

performance in other contexts? The integration process into the community and the labour market seems to be more difficult in such cases, because, for example, employers might think that these individuals are not able to produce performances in a working context. Furthermore, if the Council has noticed that, employers do not generally consider documents assessing competences inpeople without disabilities very trustworthy, this becomes even more evident in case of people with disabilities. If, for instance, a person with disabilities attended a course oncomputer science, how well would s/he be able to use computer programs in the workplace or in the community,without being supported by educators? Or what level of support does s/he need? Assessment systems must allow us to answer these questions.

2.3. Opportunities offered by the integration of systems from the clinical, social and training fields

The assessment competencesin people with disabilities is not an exclusive necessity within the training field. It appears to be a need in all fields, particularly in relation to the effective design of pathways of integration into the community and the workplace.

Moreover, we have to remember that, when dealing with assessment processes, it is essential to apply assessment procedures to people, who are entering a training course, in order to be able to identify their progress and the effectiveness of the methods and contents, accuratelyapplied.

What we are proposing, is the integration of assessments coming from: the field of social and clinical interventions, the training sector, the context of daily life and the evaluation of previous experiences.In particular, what could be useful, from our point of view and in accordance with the set goals, is the development of an initial profile – meaning a presentation of the person to which an assessment system, mainly based on practical tests, can be applied.

To build the initial profile, we propose to use the assessment system featured in the D-Active project research (www.dactive.eu). In brief, researchers have used: ICF CheckList, WHODAS II (36 Items), WHOQoL (24 items), CBI (Caregiver Burden Inventory) (24 Items), Ca.R.R.I (Caregiver Role Relation Interview).

Research data were collected with the help of people with disabilities and their caregivers (family and reference operators). Other information about possible work or integration experiences can be added to such assessment results.

Data concerning caregivers can be useful to identify improving and contrasting elements of relational nature, in the life context. Of course, as far as the individuals involved in the project are concerned, the assessment has already been carried out, and, therefore it is employable (except for the working experience list that could be originated).

The personal profile of the individual can be used as a basis for course design and for the development of assessment tests and methods (for instance, with reference to the degree of complexityand to the tools to be used).Coupled with the outcomes of assessment procedures at the end of the course, this profile can help with the development of an individual presentation document. A grid for the development of the admission protocol to the training process could easily be designed, by merging the test progress results.Another small grid with the list of work or integration experiences, and with the comments of the individual's and possible tutor's points of view,could also be added to the test evaluations. The comparison can provide information about the individual level of awareness.The profile as such is apt for use in the training, development and assessment issues and can constitute the connecting element for interventions of specialists, from different sectors. It provides data on: perception of the quality of life, resources and opportunities, difficulty areas, aspects relating to the context.

2.4 Aspects of the development of systems and tests to assess competences

Bearing in mind that, the proposed procedures for effective competence *certification* have to be in line with the corresponding legislative systems of the member states, the essential steps in the assessment process could be the following: first of all, it is necessary to identify the competences related to the aspects to be evaluated (here we focus on the 8 key competences); secondly, it is necessary to isolate the knowledge and skills connected with the competence to be evaluated; the third stepwould be the design of tests that identify the knowledge and skills possessed, as well as the ability to make use of these when required to produce a performance.

Taking the first step for granted, let us consider the second one: The European Council declares knowledge, skills and attitudes connected with the key competences in the document, attached to the Recommendation (within the "Education and Training 2010" program) and cited in the bibliography, as it is in the featured exercise.

The third stage relates to the test development. Taking into account that it is always necessary to involve evaluation, as well as field specialists (for specific competences), we will give general recommendations only. Important references to the development of tests and complex assessment systems are the general considerations and guidelines, underlying the so called 'performance (or 'authentic', or 'alternative') assessment' approach.

In any case, all systems make reference to tests, such as objective tests, technical work, simulation tests, etc.

Multiple choice and objective tests are generally used to assess knowledge possession, but they are not considered to be sufficient proof of whether a person is able to produce a certain performance. When addressingpeople with disabilities, we do not consider these kinds of test as a first choice of proof. If necessary, we would recommend the development

of tests that involvethe extensive use of images, pictures and even objects,as is the case in some clinical tests.

The tests, that seem to be even more appropriate from our point of view,are simulation tests, or practical technical ones alternatively, as well as role play activities (for relational competences). By simulation, we mean setting up a realistic scenario, and a context where the person can reproduce the requested performance.

Setting up a simulation test,or a practical technical one, is important:

- to identify a performance that might be representative of the use of knowledge and combined skills which are part of it (e.g. comprehension and presentation of a text, for the competence of reading in the mother tongue);
- to break down the performance process into its key passages;
- to identify performance indicators and descriptors(e.g.clearnessin presentation, numerical completeness of passages to be in a finite number, accuracy and completeness of contents in the process passages etc.)
- to score the descriptors (e.g. the performance is broken down into a 5 passage process, each passage is considered of equal importance and therefore, on a total score of 10, each passage is scored 2 points – if the candidate performs all passages, s/he will get 10 points, referred to the completeness of the passages; once this evaluation is finished, the next step could be, for example, accuracy assessment, taking into consideration if each passage has been performed with the same accuracy, in the same way, etc.)
- to design assessment grids;
- to make the tests' contexts as similar as possible for all participants, in order to reduce the influence of variables, making the assessments incomparable.

In our opinion, some aspects that should always be included (as indicators/descriptors) in the assessment of performance in people with disabilities, are the following:

- the extent to which the participant is capable of developing the performance autonomously
- the extent to which the individual seems capable of producing the performance in different contexts and with different people
- the level of awareness of the actions s/he performs
- the ability to imagine oneself as a person inside one'sown context, capable of producing those performances, and to imagine the potential consequences in the related world.

In addition to the practical test, it can be advisable to carry out an interview - not to be intended as an 'interrogation', but a moment of reflexion and exchange of views, to assess the level of awareness, and the ability to identify possible difficulties occurred during the course and the tests.

From the considerations outlined above,it can be inferred that a good assessment needs:

1) integration of different types of test; 2) scheduling of further tests, in order to assess the different competences as a whole.

As was said before, the context(physical and relational environment) is a particularly important element, in people with intellectual disabilities. A person can actually acquire certain competences, but s/he may have difficulties with a test if it is run in a context that isdifferent from the usual one, and in the presence of new people.

In reference to this issue, it can be advisable:

- for the course to include the training of context flexibility, being considered as an essential competence to develop
- to schedule more tests in the assessment phase: one within the habitual context, one in a standard non-habitual context, for example
- It can also be particularly useful to foresee the alternation of individual and group tests. The latter could be especially apt for evaluating relational competences.

3. Didactics and exercises

We think the most suitable methodologies to be applied, are those based on active participation, those referring to constructivism, and originating from the concept ofindividual development as an autopoietic system that organises and modifies itself, according to its personal constructed organization, and the interpretation of environmental inputs.

In the practice oftraining, simulations, experiences, games, practical tests and case-handling can be used. It can also be useful not to provide all theoretical elements at first, but to keep up with the following structure:

- to provide some general theoretical guidelines to allow participants to identify contexts and goals;
- to organize practical tests in small groups;
- to organize a guided discussion for the group work presentation,in order to highlight the detected solutions, critical issues and potential 'training deficiencies';
- to introduce new theoretical material, also with the aid of slides and pictures, taking into account previous discussions, deficiencies and training needs, proposed by the learners.

This procedure can be repeated up to the elapse of the allocated 6 hours.

Considering that the educator takes part in the assessment phase, but has to refer to the evaluation specialists and the procedures established in his/her country anyway, exercises could be of two types:

1) Presentation and analysis of a case suggested by means of the assessment profile,indicated in the D-Active project research. Knowing the profile will also facilitate the construction of the subsequent training course.

2) Taking into account the profiles, considered participants (divided into small groups) could try to set up assessment tests, referred to one key competence. For the test construction, one can make reference to the passages indicated in the previous paragraphs, or directly to more structured systems, like the 'performance assessment'.

Referring to exercise 1), participants could separate into groups, try to study a profile and then present it to the others, simulating in turns the presentation of the individual to a committee for the admission to a course, vocational training or to an employer.

Referring to exercise 2), it could be useful to start with the attempt of building an assessment test,in relation to the first key competence, as it is probably the easiest one to understand. The official definition can be the starting point.

Communication in the mother tongue

Definition	Knowledge	Skills	Attitude
Communication in the mother tongue is the ability to express and interpret concepts, thoughts, feelings, facts and opinions in both oral and written form (listening, speaking, reading and writing), and to interact linguistically in an appropriate and creative way, in a full range of societal and cultural contexts; in education and training, work, home and leisure.	Communicative competence results from the acquisition of the mother tongue, which is intrinsically linked to the development of an individual's cognitive ability to interpret the world and relate to others. Communication in the mother-tongue requires an individual to have knowledge of vocabulary, functional grammar and the functions of the language. It includes the awareness of the main types of verbal interaction, a range of literary and non-literary texts, the main features of different styles and registers of language, and the variability of language and communication in different contexts.	Individuals should have the skills to communicate, both orally and in written form, in a variety of communicative situations and to monitor and adapt their own communication to the requirements of the situation. This competence also includes the abilities to distinguish and use different types of texts, to search for, collect and process information, to use aids, and to formulate and express one's oral and written arguments, in a convincing way appropriate to the context.	A positive attitude towards communication in the mother tongue involves a disposition to critical and constructive dialogue, an appreciation of aesthetic qualities and a willingness to strive for them, and an interest in interaction with others. This implies the awareness of the language impact on others and a need to understand and use the language, in a positive and socially responsible manner.

Introducing this description, participants could be divided into small groups and try to think about possible tests, following the passages described in the previous paragraphs.

It could be suggested to integrate more tests, such as:
- Analysis, comprehension and presentation of a text.
- Role-play activities in different contexts (communication in informal contexts, e.g. in a bar, store or job interview).
- Simulation of a dialogue to communicate one's own needs and expectations.

Participants could try to develop the test structure and the score assignment, always taking into consideration the profiles of people with disabilities.Small groups could then present their outputs to the others and the trainer. The work's critical issues and points of strengthcould then be highlighted in a discussion, and with the trainer's help.

4. Example(s) of best practice

An important reference in terms of good practice is the system indicated by the *Tuscany Regional Authority,* through the REGIONAL SYSTEM OF COMPETENCES IN THE CONTEXT OF NATIONAL MINIMUM STANDARS *Regional Standards for the Description, Training, Recognition and Certification of Competences rev. 04.0208*. *The Regional Authority of Tuscany* has provided a repertoire of professionals and a specific system of learning assessment and competence certification, introducing and training specialists with specific expertise for assessment. They also indicate that, in case of an examination board, the participation of assessment specialists, experts from the workplace and institutional representatives should be integrated. In this context, it might be interesting to think of specializations, with regards to the evaluation of different kinds of disability, to facilitate the work of skilled assessment experts when creating tests.

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The recommendation is one of the outputs of the joint efforts of the European Commission and the Member States in the context of the program "Education and Training 2010". For further information see: http://ec.europa.eu/education/index_en.html.

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Performance assessment, authentic assessment, integrative assessment, holistic assessment, assessment for learning o formative assessment are approaches and systems proposed by a long list of authors form different countries, as Giselle O. and Martin-Kniep, among others.

UNIT 4 Models for dealing with parents and with their social and working environment

Partner 6 - Romania

1. Aims of the unit

This unit sets out to explore the personal impact, disability can have on family members and family structure, taking into consideration the dynamic nature and interactivity of the family system.

Starting from a perspective,which takes into consideration the family as a whole system, we can develop services for people with disabilities and their families, such as specific educational and therapeutic interventions.

Another aim of this unit is to emphasise the frames of reference and contextual factors of models, for dealing with parents and with their social and working environment. Furthermore,it identifies the practical ways for the involvement of the family and the people that are a reference to the person with disabilities, in his/her education and therapeutic project. Our final goal is to link the family with formal and informal supports that are consistent with their cultural beliefs, traditions, and practices.

It is essential to ensure to people with disabilities,the right to achieve their educational potential,providing them with every possible support they might need. The familyplaysan important rolein educatingchildren withdisabilities, and thelack of family care can cause emotional disorders in children, such as stress, anxiety, depression, and developmental impairments.Also, certain educational methods (severity, excessiveauthority, possessiveparents) can inhibitthe child'semotionaldevelopment.

Finally, home enclosure and family withdrawal from external social interaction are an impediment to the development of social competences in an individual with disabilities. Additionally,the attitudes of the social network influence the attitudes and behaviour in the person with disabilities.

2. Exploring childhood disability within the context of the family

Many parents become desperate when their child is diagnosed with a disability, thinking that s/he will not be able toexperience the same quality of life as other children of the same age without disabilities.

Families withdisabled children living at home face extraordinary challenges in relation to the individual's disability and the family's capacity to provide support. In order to

remain the essential core of societythat a family represents, its members deserve constant support, that enables the family to keep up its independence.

The trials faced by the disabled and their families change during the course of their lifetimes. They depend on the stage of maturity and the challenges posed by the disabled person at each phase of the life cycle (cf. Marshak et al., 1999).

Parents' attitudestowards thedisabledchilddepend on severalfactors,including the severity of the disability, emotional, social andcultural factors (which determine how the family members cope with the situation), the family's expectations, the degree to which, intellectual potentialities are valued, and the extent to which the child has not matched paternal expectations, in the sense of intellectual and professional achievements.

3. Understanding family function and the impact of disability on a family

A family is regarded as an interactive set of relationships, both, between the members of the family and with society. Family system theories focus on a complex interactional model of family functioning, each family representing a social system, with each family member constituting a part of the system (cf. Broderick, 1993).

Understanding family functioning is vital, when the existence of a child with disability has to be taken into consideration, because this has implications on all family members, family life and family dynamics.

Disability has an individual impact on all family members, and the almost monolithic concept of the inevitability of distress, crisis, and pathology has recently been replaced by the recognition of an extreme variability of family response, and an understanding of the importance of identifying the antecedent causes of that variability (cf. Glidden et. al., 1993).

The ability of the family system to adapt to the impact of disability depends on some contextual factors, such as: financial resources, access to health or educational services, home and community safety and convenience, domestic tasks and chores, care-giving tasks, social support, family relationships, father's and mother's specific roles, sources of information and advocacy.

In practice, we often meetparents,who experiencea deep senseof guilttowards the child, feelingresponsible, ina verydistinctive way, of giving birth to a child with disabilities.Thereare cases in which,therelationship between thetwo parents isunder a constant suspicion and tension, each parent holdingthe other responsible for the disability inside the family.

Sometimes a family can behave in a disempowering and infantilizing way, even when intending to act in the disabled person's best interests. Family members and also caregivers are often restrictive or discouraging as regardsactive pursuits, apparently fearful of detrimental effects on health, that may lead to increasing dependence.

Problems may also arise when, the disabled child is not the only child. His/her sibling(s) may not feelvaluedenough,because the parents' attention is mostly directedtowards the childwith special needs.

The family network is essential to identify the condition of the person with disabilities. In this context, the responsibility of educationalists is to stimulate and support the families of children with disabilities, in their efforts of integrating their children into society and of increasing their independence, giving them the opportunity to demonstrate their skills and talents, through participation in a constant system of social activities.

4. Building resilience within families experiencing childhood disabilities

During the past two decades, family-centred care has evolved as the standard care for children with special health care needs. Therefore, a strong partnership between the family and the providers, who must work together to address issues and barriers regarding access to comprehensive care and related services, is a prerequisite(cf. Denboba et al., 2006).

Recent findings reinforce the need for family membersto be actively involved in early interventions, since child disability is far more than a medical issue (cf. Bailey et al., 2007). People experiencing disability have to deal with a lot of pressure and stress, that stems from the disability's biopsychosocial demands. The family can provide them with encouragement, as well as support, and reduce helplessness, isolation, and despair, through cooperation and use of mutual resources (cf. Feigin, 2002). Personal factors, emotional support, social support, instrumental support and financial support are important.

Informal support systems play an important role in the promotion of optimism and in the enhancement of confidence in parenting skills, adding further support to a growing body of research on the important role of informal support in family adaptation to disability. Both formal support (like early intervention services) and informal support (family and community supports) are important for family adaptation, but likely operate in different ways, with different impacts on families (cf. Bailey et al., 2007).

Parentshave to be aware of the fact that, the way they educate their child within the family is very important to their child's development. Only by providing adequate support on their side, can the child'spotential be fully developed. Levelheadedness and patience are crucial,because advancement in development takes time, especially in children with disabilities.

It is important for parents and professionals to utilize positive resources, in order to be able to cope with a variety of special circumstances, connected with the stress factors, and to adapt them to meet the changing individual needs. It is a teamwork approach that involves family members, as well as professionals. Together, they must strive to improve the *abilities*

of disabilities, not only for the disabled child, but also for the entire family (cf. NICHCY, 1994).

5. Didactics and exercises

Educationalists can use various training methods in order to support the families of children with disabilities in accepting, adapting and adjusting to the complex needs of the children, and also, in applying a wide range of relevant therapies, tailored to the individual needs of children.

The involvement in family advocacy includes helping them in becoming self-reliant, developing partnerships with care providers and support services, acquiring the necessary skills, supports and tools to make informed decisions, learning about their child's or other developmental disabilities and useful intervention strategies, having treatment options available, linking them with other families and support systems, so they can take an active role in their child's treatment and recovery, and empowering them to act on their own behalf, to secure whatever they need to live a life as normal as possible.

Challenges that may arise when working together with the social and working environment are the following: financial constraints, scheduling conflicts and time constraints, overcoming stigma, language, and other cultural barriers, blaming or labelling each other, mediating differences in perspectives, values, and expectations, the parents' reluctance or insecurity to get involved, overcome of any perceived feelings of inadequacies and, finally, avoidance of paternalism and emphasis on equality of all persons involved.

The family, as a social institution, must be supported in providing a dependable social environment in which people can lead their lives. For this purpose, some of the most proposed learning objectives and competences (cf. Guide to Developing Training Curriculum on Families, Disability, and Culture for MCH Trainees and Professionals, 2010) are:

• Gainof knowledge concerning key resources, to be used in the access of information on family support and other community services for children with disabilities, and special health care needs and their families.

• Identification of activities and strategies to promote advocacy, capacity building and systems change, to address gaps between what families identify as their need for resources, support and services and what is available to them in their communities.

• Reflection on the 'lessons learnt'concerning families, disability and culture, and how this applies to their own practices.

The possible strategies that can be used practically are: parent support groups; parent skills training; family-friendly services; continuum of care/services (integration of services); culturally sensitive care; building of partnerships; holistic understanding of developmental disorders and treatment; bridge between natural and formal supports; education of the

public on stigma, discrimination; advocacy (successful advocacy teaches and empowers families to do what is needed for the improvement of their family; advocacy is not successful when the family becomes totally dependent and is not actively engaged in the process of independence) etc.

A high degree of flexibility is recommended in program implementation, covering both the content and the kind of implementation (selection of teaching methods, timing, different learning contexts with different learning requirements etc.).

The recommended methods of teaching are: interactive lectures; discussions; presentations; case studies; role playing; self-study.

Methodological and pedagogical learning key points: participative and collaborative learning, experimental learning; trying to find out as much as possible about the biography of the trainees; use of few and simple exercises; more practical than theoretical work; use of easy words, simple concepts; use of a wide range of exercises; use of real and simple case studies; involvement of the trainees in group work; small groups; promotion of volunteer work.

6. Example(s) of best practice

Examples of the best practicesto deal with parents and with the social and working environment in Romania are provided by nongovernmental organizations (NGOs). *Inclusive Romania* is an NGO and non-profit organization that supports social inclusion of disabled people, with 22 member associations from all over the country, members of *Inclusion International* and *Inclusion Europe*. A few years ago,*Inclusive Romania* proposed the establishment of a public - private partnership, in order to adopt the *National Strategy for Equal Opportunities for Persons with Disabilities* (cf. Leampar et al., 2003).

The result of the lobbying campaign was positive: on 31 October 2002 the Romanian Government approved the *National Strategy for Special Protection and Social Integration of People with Disabilities in Romania*. The strategy was developed, based on the *United Nations Standard Rules on Equalization of Opportunities for Persons with Disabilities*. The purpose of this strategy was to harmonize the work of all governmental and non-governmental organizations involved in supporting people with disabilities, and to align their policies with relevant international standards, providing a basis for future policies concerning disabled people.

The strategy emphasized the importance of increasing a network of services, in order to support independent living in the family; the role of residential services (community-based) for children and adults with disabilities; the need to implement inclusive education and inclusive employment.

An essential aspect of this strategy was the avoidance of institutionalization because the experience we have made in the past two decades has proved that, no matter how much money is invested in institutions, their quality standards remain consistently low.Therefore, deinstitutionalization and the return into the family, under the condition of the family's active support, is the only way to increase the quality of life of people with disabilities in Romania.

Subsequently, starting from the mentioned initiatives of NGOs in Romania, the Romanian Government issued a new resolution approving the *National Strategy for Protection, Integration and Social Inclusion of Disabled Persons* in the period 2006-2013, based on the idea of supporting families that are affected by disability.In this referential document, it is emphasized that the needs of people with disabilities and their families are diverse, and that it is important to raiseawareness within the community, addressing both the person and the various aspects of his/her life (cf. GD 1175, 2005).

The target groups of this legislative act are disabled people, their families or their legal representatives, and also the local community. The proposed specific interventions includes training sessions for family members in such situations.

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UNIT 5   Collaboration with professionals from diverse fields, development and integration of assessment tools into existing models

Partner 3 – Italy (Regione Veneto)

1. Aims of the unit

Starting from the principles that characterise the International Classification of Functioning, Disability and Health (ICF), the aims of this unit are the following:

a) The introduction of a means of multidimensional assessment derived from the ICF, called the *Multidimensional Assessment Plan for Persons with Disabilities*(S.Va.M.Di. - *Scheda di Valutazione Multidimensionale delle Persone con Disabilità*), which aims at being an effective means of sharing between various health professionals (both medical and social),with regards to the state of health and capabilities of a person with disabilities.

SVaMDi is a checklist consisting of selected items, that facilitate the creation of the most comprehensive description of the individual in terms of his/her environment and condition. It includes the ICF's fundamental concepts, structure and classification via codes and competences, while introducing an evaluative aspect, which offers the possibility to create profiles addressing the degree of impairment per se, as well as the mobility. In the first profile, the emphasis is placed on impairment and capability, while in the latter the focus is laid on performance and environmental factors.

b) The definition of a professional code for those involved in the use of SvaMDi, as well as the specific competences of all health professionals.

c) The provision of suitable educational contents, specifically aimed at the development of an ICF and SVaMDi knowledge base, and the correct use of the section dedicated to activities and participation, for those involved in the educational system.

d) Having a closer look at the section on activity and participation of the SvaMDi, due to its difference to the ICF: Using the SvaMDi,it is easier to detect environmental factors that influence an individual's performance than when using the ICF.

2. ICF and SVaMDi checklist

The ICF is a classification of the "components of health", which allows the identification of the constituent elements of health. A list of environmental factors, which describe the context in which the individual lives, is also included.The classification is based on an alphanumeric code, in which the letter *b* represents the body (functionality), *s* stands for

structure (body structure), *d* for activity and participation and *e* for environment (contextual factors).

The term 'activity',according to the ICF, refers to an individual's ability to execute actions or tasks, while 'participation' refers to the involvement of an individual in daily life situations, with reference to "contextual factors", which are divided into environmental factors (external influences on functionality) and personal factors (internal influences on functionality).

Within the alphanumeric code, the letters are followed by numbers which provide information about the type of disability and its severity. The codes require a qualifier,that indicates the extent to which the health of the individual allows functionality.

According to the World Health Organization (WHO), the state of one's health should be classified primarily in accordance with the ICD-10 (International Classification of Diseases and related Health Problems) in terms of aetiology, and in accordance with the ICF in terms of functionality and disabilities associated with health. Since the two classifications are complimentary, applying them both makes it possible to obtain more accurate information about an individual's state of health, in a broader context.

SVaMDi maintains the conceptual foundations of the ICF classification, in terms of its structure and descriptive mode. It consists of a list of items (reduced if compared to the ICF list) which can be used to obtain a description and a functionality profile of the individual, to whom they are applied.

The assessment tool* consists of the following sections:

- cover page of the plan/introduction,
- impairment of functionality,
- impairment of body structure,
- activity limitations and participation restrictions, due to environmental factors,
- contextual information,
- evaluation of social environment.

Unlike the ICF, the tool is used to verify periodically the profileof an individual and facilitate evaluation. By doing so, profiles of the impairment severity and of a person's functionality are obtained, and then used by the agencies in charge of managing the distribution of resources, such as services and economic assistance. In practice, this tool is used as a means of sharing information within the regional team dealing with the area of health and functionality, that must seek to intervene with two principal aims in mind:

a) The improvement of the quality of life of the disabled person.

b) The optimisation of the usage of available resources, whilst aiming at limitingdis-homogenisation in the region.

3. Collaboration with professionals from different fields

Within the Veneto Region, the SVaMDiis used during the multidimensional assessment unit for disability (U.V.M.D. - "Unità di Valutazione Multidimensionale per la Disabilità) meetings, in which each team of professionals involved has its own role and knowledge about the disabled person subject to assessment. A comparison of opinions is made, in order to plan the intervention, according to the situation at present or in the immediate future, in relation to the disability and life environment.

The health professionals involved in UVMD have specific functions:

- The doctor, responsible for the health services in the district where the individual resides, convenes the meeting,
- The general practitioner, physiatrist, or neuropsychiatrist (psychiatrist or psychologist - if the disability concerns the mental aspect), who knows the pathology makes the diagnosis,
- The speech therapist, physiotherapist or psychomotility therapist deals with rehabilitative needs,
- The social worker and educator, who know the individual's capabilities and the environment liaise with and provide information for the family.

Each professional completes the section related to his/her competence: the healthcare workers complete and sign the part related to "Functions and body structure", after coding the diagnosis in accordance with the ICD-10 and describing the health situation and possible pharmacological therapy.The welfare workers complete and sign the part related to "activity and participation", considering both environmental and personal factors.Finally, the social worker completes the social assessment, which includes: marital status, education, work experience, qualifications, family situation, services currently being administered, housing, and economic situation.

The final stage of the process is the codification of the individual project and the writing of the minutes(by the person in charge of the district/UVMD), that are then signed by everyone attending the meeting.

4. Didactics and exercises

Case study with a short introduction and categorisation utilizing the SVaMDi

In the case of an individual, who regularly goes to an Occupational Day Care Centre, a Multidimensional Assessment Unit verifies the contents of the report on the individual in question and begins the interactive task of making a comparison with the codes.

Name: Chiara

Date of Birth: 25/04/1985

Diagnosis: Cerebrovascular Disease (G80); Spastic Tetraparesis (G82.4); Moderate Mental Retardation (F71); has been a certified invalid since 1999.

Chiara is 26 years old, and lives in Padua with her parents and sister.

She is only able to walk with assistance, usually using a walker frame to move independently.

She has difficulties in making certain movements, for example sitting down on the floor and then standing up again, but is able to get up from a bed or a chair without assistance.

Chiara has been going to the Occupational Day Care Centre for approximately eight years. She is involved in painting, ceramic, information technology, and communication workshops.

In general, she understands the tasks assigned to her, provided that the tasks are simple and can be performed autonomously. However, when the activities are more complex, including multiple stages, and she is not able to perform them alone, she usually gives up.

She has good gross motor skills but is unable to manipulate small objects, execute tasks requiring precision or lift and carry objects. Chiara speaks quite well and actively participates in a conversation.

She does not display difficulties in terms of gestural communication; when she needs to communicate things of importance such as her emotions and desires she prefers to use the computer, whose basic functions she is able to use without external support.

She reads almost perfectly when someone helps her, but without help she encounters difficulties. She is able to copy everything - drawings and sentences - but she needs help when calculating (apart from simple additions).

In relation to Chiara's relationship with others, she is able to behave politely demonstrating respect and cordiality, as is required by the situation. She is also able to establish contact and develop a relationship with strangers.

At home, Chiara's mother cares for her, but Chiara is able to buy little things in the shops, such as coffee and newspapers.

Chiara can prepare a sandwich on her own, but her mother cooks and serves the meals.

She demonstrates enough self-sufficiency in the care of herself: she brushes her teeth, she goes to the bathroom on her own, but she needs help having a shower and getting dressed.

In her free time she does not go out with friend, due to the reluctance of her family in permitting any kind of involvement, consequently she does not participate in community life.

Furthermore, her family manages every economic aspect of Chiara's life.

After having read the report, educators attending the training course are divided into two groups and complete the sections relating to "Activity and Participation" with the information obtained from the report, using the required codes and qualifiers.

PART 2/3: ACTIVITY LIMITATIONS/ PARTICIPATION RESTRICTIONS & ENVIRONMENTAL FACTORS

• Activity is the execution of a task or action by an individual. Participation is involvement in a life situation.

• Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may have in involvement in life situations.

• The environmental factors are made up of the attitudes towards the physical environment, society and to the where the individual lives and leads his life.

The Performance qualifier indicates the **extent of Participation restriction** by describing the persons **actual** performance of a task or action in his or her current environment. Because the current environment incorporates the societal context, performance can also be understood as "involvement in a life situation" or "the lived experience"of people in the actual context in which they live. This context includes the environmental factors – all aspects of the physical, social and attitudinal world that can be coded using the Environmental factors. The Performance qualifier measures the difficulty the respondent experiences in **doing things, assuming that they want to do them.**

The Capacity qualifier indicates the extent of Activity limitation by describing the **person's ability** to execute a task or an action. The Capacity qualifier focuses on limitations that are inherent or intrinsic features of the individual. These limitations should be direct manifestations of the respondent's health state, **without assistance.** By assistance it is intended the help of another person, or assistance provided by an adapted or specially designed tool or vehicle, or any form of environmental modification to a room, home, workplace etc.. The level of capacity should be judged relative to that normally expected of the person,

or the person's capacity before they acquired their health condition.

| ACTIVITY AND PARTICIPATION QUALIFIERS | ENVIRONMENTAL FACTOR QUALIFIERS |

First Qualifier: Performance Extent of Participation Restriction	Second Qualifier: Capacity (without assistance) Extent of Activity limitation

0 No difficulty: the person does not have any problems

1 Mild difficulty: a problem that is present less than 25% of the time, with an intensity a person can tolerateand which has occurred rarely in the last 30 days.

2 Moderate difficulty: a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which has occurred occasionally in the last 30 days.**3 Severe difficulty:** a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the person's day to day life and which has occurred frequently in the last 30 days.

4 Total difficulty: a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which has occurred every day for the last 30 days.

8 Not specified: there is insufficient information to specify the severity of the difficulty.

9 Not applicable: it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in premenarchal or post-menopausal age).

Environmental qualifiers: Barriers or facilitators

0 No Barriers	0 No facilitator
1 Mild Barrier	+1 Mild facilitator
2 Moderate Barrier	+2 Moderate facilitator
3 Severe Barrier	+3 Severe facilitator
4 Total Barrier	+4 Total facilitator
8 Not specified	+8 Not specified facilitator
9 Not applicable	9 Not applicable

NB: It is possible to insert up to a maximum of five environmental factor codes for each "Activity and Participation" Code. Should it be necessary to insert diverse environmental factors for the same code, these should be specified in the notes on page 10/16.

Short list of Categories Activity and Participation			Environmental Factors Codes and Qualifiers									
			Code 1		Code 2		Code 3		Code 4		Code 5	
	performance	capacity	Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier
D1. LEARNING AND APPLYNG KNOWLEDGE												
d110 Watching												
d115 Listening												
d130 Copyng	0	0										
d166 Reading	1	2	e 340	+1								
d169 Writing												
d172 Calculating	2	3	e 340	+1								
d175 Solving problems												
D2. GENERAL TASKS AND DEMANDS												
d210 Undertaking a single task	0	1	e 340	+1								
d220 undertaking multiple tasks	2	3	e 340	+1								
D3. COMMUNICATION												
d310 Communicating with-receiving-spoken messages	0	0										
d315 Communicating with-receiving-nonverbal messages	0	0										
d330 Speaking	1	1										
d335 Producing nonverbal messages												
d350 Conversation												
d360 Using communication devices and techniques	1	3	e 340	+2								
D4. MOBILITY												
d410 Changing and maintaining body position	0	2	e340	+2	e310	+2						
d430 Lifting and carrying objects	2	3	e 340	+1	e310	+1						
d440 Fine hand use	2	2										
d450 Walking	1	4	e 340	+2	e310	+2						
d455 Moving around												
d465 Moving around using equipment	1	4	e120	+3								
d470 Using transportation	0	0										

Short list of Categories Activity and Participation	performance	capacity	Code 1		Code 2		Code 3		Code 4		Code 5	
			Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier
d475 Driving	4	4										
D5. SELF-CARE												
d510 Washing oneself	0	2	e310	+2								
d520 Caring for body parts	0	2	e310	+2								
d530 Toileting	0	0										
d540 Dressing	0	2	e310	+2	e340	+2						
d550 Eating												
d560 Drinking												
d570 Looking after one's health												
D6. DOMESTIC LIFE												
d620 Acquisition of goods and services												
d630 Preparing meals	0	3	e310	+3								
d640 Doing housework												
d660 Assisting others	3	3										
D7. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS												
d710 Basic interpersonal interactions	0	0										
d720 Complex interpersonal interactions												
d730 Relating with strangers	1	1										
d740 Formal relationships												
d750 Informal relationships												
d760 Family relationships												
d770 Intimate relationships												
D8. MAJOR LIFE AREAS												
d810 Informal education												
d820 School education												

Short list of Categories Activity and Participation	performance	capacity	Code 1		Code 2		Code 3		Code 4		Code 5	
			Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier	Code	Qualifier
d830 Higher education												
d840 Apprenticeship (work preparation)												
d850 Remunerative employment												
d855 Non-remunerative employment												
d860 Basic economic transations	0	3	e 310	+2	e340	+1						
d870 Economic self-sufficiency	0	4	e310	+4								
D9. COMMUNITY, SOCIAL AND CIVIC LIFE												
d910 Community life	4	4										
d920 Recreation and leisure	3	1	e 410	2	e325	+1	e310	+1				
d930 Religion and spirituality												
OTHER ACTIVITIES AND PARTICIPATION												

Short List of Environmental factors	Short List of Environmental Factors
E1. PRODUCTS AND TECHNOLOGY	**E4. ATTITUDES**
e110 Products or substances for personal consumptions	e410 Individual attitudes of immediate family members
e115 Products and technology for personal use in daily living	e420 Individual attitudes of friends
e120 Products and technology for personal indoor and outdoor mobility and transportation	e425 Attitudes of acquaintances, peers, colleagues, neighbours and community members
e125 Products and technology for communication	e430 Individual attitudes of people in position of authority
e150 Design,construction and building products and technology of buildings for public use	e440 Individual attitudes of personal care providers and personal assistants
e155 Design,construction and building products and technology of buildings for private use	e450 Individual attitudes of health professionals
	e455 Individual attitudes of health related professionals
E2. NATURAL ENVIRONMENTAL AND HUMAN-MADE CHANGES TO ENVIRONMENT	e460 Societal attitudes
e225 Climate	e465 Social norms, practices and ideologies
e240 Light	
e250 Sound	**E5. SERVICES, SYSTEMS AND POLICIES**
	e525 Housing services,systems and policies
E3. SUPPORT AND RELATIONSHIPS	e535 Communication services, systems and policies
e310 Immediate family	e540 Transportation services,systems and policies
e320 Friends	e550 Legal services, systems and policies
e325 Acquaintances, peers, colleagues, neighbours and community members	e570 Social security services, systems and policies
e330 People in position of authority	e575 General social support services,systems and policies
e340 Personal care providers and personal assistants	e580 Health services, systems and policies
e355 Health professionals	e585 Education and training services, systems and policies
e360 Other professionals	e590 Labour and employment services, systems and policies

Note: the section has been completed only in reference to the information obtained from the report,so not all codes have been inserted.

Methodology: interactive lectures, practical exercises in small groups, role-play activities
Resources: ICF handbook, ICD-10 handbook, SVaMDi Checklist, computer, PowerPoint, video projector, report on a case-study for practical exercises.

5. Example(s) of best practice

During 2005/2006 the first ICF training program was carried out in all Local Social Health Units in the Veneto Region, involving approximately 700 social and health-care workers.
The objective of the project was to verify the usefulness of the ICF in social and health services, in order to evaluate and monitor individual disability projects.
Since the initial testing in February 2007, there was a series of versions of the assessment plan until the adoption and admission of the finalised plan in June 2009, which is the version described in this unit.
The latest experience of the Veneto Region (2009/2010), related to the use of the ICF within the multidimensional assessment tool,is as follows:
- an initial training course for 55 professionals from the 21 Local Social Health Units in the Veneto Region, who afterwards became 'internal educators' in their territory,
- followed by a second phase which consisted of another training course for social and health-care professionals, held by internal and external educators.

In the second phase the professionals involved in the project were:

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disability and active citizenship

District managers; Primary Care and General Medicine doctors; psychiatrists; neuro-psychiatrists; psychologists; social workers; educators and physiotherapists.

These professionals collaborated on a sample, chosen in accordance with precise parameters of: age, sex, invalidity type (motor, mental impairment, mental disease), disability type (functionality, movement, sensory) and care service (semi-residential, residential, work integration service, domiciliary care).

Data obtained from the completion of the SVaMDi were sent to the Regional Observatory.

Currently, within the realm of the Veneto region, the SVaMDihas become the official tool for evaluatingdisability conditions for the Unit of Multidimensional Evaluation, allowing them to define individual projects in the light of profiles of the severity of the impairment and the functionality that can be reached.

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http://www.news.ulss16.padova.it

CONCLUSION

Bearing in mind the contents of the five units of the present handbook, the following can definitely be concluded: When fostering activity and participation (active citizenship) of people with disabilities on a common European level,a wide range of aspects must be taken into consideration. To illustrate this fact, the reader will be provided conclusively with a short summary of the units.

As shown in unit 1,a lot of different domains included in the ICF, ranging from mental functions to products and technology, influence a person's ability to be active and to participate. Therefore, as far as educationalists are concerned,a high level of flexibility and creativity is required when working on the various skills with disabled people (cf. the examples of best practice).

Unit 2 focuses on the development of key competences defined by the European Council. In this context, the cognitive development of disabled people, as well as their ability to learn are discussed. Furthermore, the reader is provided with information on the relationship between parents (caregivers) and their children (care receivers), as well as on the issues that can arise, when their disability is put centre stage.

Compared to units 1 and 2,that are very closely related to everyday working practice, unit 3 deals with another relevant topic in this context on a more theoretical level: the question of competence assessment. Thus, educationalists are made familiar with test theory, evaluation methods, as well as competence certification for people with intellectual disabilities. Additionally, the question of comparability on a European level is discussed.

Unit 4 deals with the topics of activity and participation, from a system-theoretical point of view.Acknowledging that no man is an island, the unit deals with the role of the family in this context. Taking this a step further, the efficient collaboration of professionals from different fields is examined in unit 5. As an example of how to collaborate efficiently, the use of an assessment tool developed in Italy (Regione Veneto) based on the ICF is described, which is used by, and connects professionals from different fields.

All in all, the D-ACTIVE EDU-HANDBOOK is meant to serve as a standard framework for the model courses for educationalists taking part in the present project. Furthermore, the project partners tried to make their contribution to one of the European Council's goals by developing this handbook: the facilitation of comparability of training systems (courses) between different European countries.

APPENDIX

I.   RECCOMENDED FURTHER READING

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II.   DEFINITIONS OF RELEVANT ICF DOMAINS

"***b1: mental functions***

This chapter is about the functions of the brain: both global mental functions, such as consciousness, energy and drive, and specific mental functions, such as memory, language and calculation mental functions.

d1: learning and applying knowledge

This chapter is about learning, applying the knowledge that is learned, thinking, problem solving, and making decisions.

d2: general tasks and demands

This chapter is about general aspects of carrying out single or multiple tasks, organizing routines and handling stress. These items can be used in conjunction with more specific tasks or actions to identify the underlying features of the execution of tasks under different circumstances.

d3: communication

This chapter is about general and specific features of communication by language, signs and symbols, including receiving and producing messages, carrying on conversations, and using communication devices and techniques.

d4: mobility

This chapter is about moving, by changing body position or location or by transferring from one place to another, by carrying, moving or manipulating objects, by walking, running or climbing, and by using various forms of transportation.

d5: self care

This chapter is about caring for oneself, washing and drying oneself, caring for one's body and body parts, dressing, eating and drinking, and looking after one's health.

d6: domestic life

This chapter is about carrying out domestic and everyday actions and tasks. Areas of domestic life include acquiring a place to live, food, clothing and other necessities, household cleaning and repairing, caring for personal and other household objects, and assisting others.

d7: interpersonal interactions and relationships

This chapter is about carrying out the actions and tasks required for basic and complex interactions with people (strangers, friends, relatives, family members and lovers), in a contextually and socially appropriate manner.

d8: major live areas

This chapter is about carrying out tasks and actions required to engage in education, work and employment and to conduct economic transactions.

d9: community, social, and civic life

This chapter is about the actions and tasks required to engage in organized social life outside the family, in community, social and civic areas of life.

e1: products and technology

This chapter is about the natural or human-made products or systems of products, equipment and technology in an individual's immediate environment that are gathered, created, produced or manufactured. The ISO 9999 classification of technical aids defines these as "any product, instrument, equipment or technical system used by a disabled person, especially produced or generally available, preventing, compensating, monitoring, relieving or neutralizing" disability. It is recognized that any product or technology can be assistive.

(See ISO 9999: Technical aids for disabled persons - Classification (second version); ISO/TC 173/SC 2; ISO/DIS 9999 (rev.).) For the purposes of this classification of environmental factors, however, assistive products and technology are defined more narrowly as any product, instrument, equipment or technology adapted or specially designed for improving the functioning of a disabled person.

e3: support and relationships

This chapter is about people or animals that provide practical physical or emotional support, nurturing, protection, assistance and relationships to other persons, in their home, place of work, school or at play or in other aspects of their daily activities. The chapter does not encompass the attitudes of the person or people that are providing the support. The environmental factor being described is not the person or animal, but the amount of physical and emotional support the person or animal provides.

e4: attitudes

This chapter is about the attitudes that are the observable consequences of customs, practices, ideologies, values, norms, factual beliefs and religious beliefs. These attitudes influence individual behaviour and social life at all levels, from interpersonal relationships and community associations to political, economic and legal structures; for example, individual or societal attitudes about a person's trustworthiness and value as a human being that may motivate positive, honorific practices or negative and discriminatory practices (e.g. stigmatizing, stereotyping and marginalizing or neglect of the person). The classified attitudes are those of people external to the person whose situation is being described. They are not those of the person themselves. The individual attitudes are categorized according to the kinds of relationships listed in Environmental Factors Chapter 3. Values and beliefs are not coded separately from the attitudes as they are assumed to be the driving forces behind the attitudes.

e5: services, systems, and policies

This chapter is about: 1. Services that provide benefits, structured programs and operations, in various sectors of society, designed to meet the needs of individuals. (Included in services are the people who provide them.) Services may be public, private or voluntary, and may be established at a local, community, regional, state, provincial, national or international level by individuals, associations, organizations, agencies or governments. The goods provided by these services may be either general or adapted and specifically designed. 2. Systems that concern administrative control and organizational mechanisms, and are established by governments at the local, regional, national, and international levels, or by other recognized authorities. These systems are designed to organize, control and monitor services that provide benefits, structured programmes and operations in various sectors of society. 3. Policies constituted by rules, regulations, conventions and standards established by governments at the local, regional, national, and international levels, or by other recognized authorities. Policies govern and regulate the systems that organize, control and monitor services, structured programs and operations in various sectors of society" (ICF Browser, online: http://apps.who.int/classifications/icfbrowser/).

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