COUNCIL OF EUROPE

COMMITTEE OF MINISTERS

(PARTIAL AGREEMENT IN THE SOCIAL AND PUBLIC HEALTH FIELD)

RESOLUTION AP (84) 3

ON A COHERENT POLICY FOR THE REHABILITATION OF DISABLED PEOPLE

(Adopted by the Committee of Ministers on 17 September 1984 at the 375th meeting of the Ministers' Deputies)

The Representatives on the Committee of Ministers of Belgium, France, the Federal Republic of Germany, Italy, Luxembourg, the Netherlands, the United Kingdom of Great Britain and Northern Ireland, these states being parties to the Partial Agreement in the social and public health field, and the Representatives of Austria, Norway, Switzerland, Spain and Portugal, these states having participated in the activities of the Committee on the Rehabilitation and Resettlement of the Disabled of the above-mentioned Partial Agreement since 11 September 1962, 6 June 1974, 1 January 1975, 15 May 1979 and 2 October 1981 respectively,

Considering that under the terms of its Statute, the aim of the Council of Europe is to achieve a greater unity between its members for the purpose of safeguarding and realising the ideals and principles which are their common heritage and facilitating their economic and social progress ;

Having regard to the provisions of the Brussels Treaty, signed on 17 March 1948, by virtue of which Belgium, France, Luxembourg, the Netherlands and the United Kingdom of Great Britain and Northern Ireland declared themselves resolved to strengthen the social ties by which they were already united ;

Having regard to the Protocol modifying and completing the Brussels Treaty, signed on 23 October 1954 by the signatory states of the Brussels Treaty, on the one hand, and the Federal Republic of Germany and Italy, on the other hand ;

Observing that the seven States Parties to the Partial Agreement, which have resumed, within the Council of Europe, the social work hitherto undertaken by the Brussels Treaty Organisation and then by the Western European Union, which derived from the Brussels Treaty as modified by the Protocol mentioned in the fourth paragraph above, as well as Austria, Norway, Switzerland, Spain and Portugal which participate in the activities of the Committee on the Rehabilitation and Resettlement of the Disabled, have always endeavoured to be in the forefront of progress in social matters and also in the field of public health and have for many years undertaken action towards harmonisation of their legislation ;

Considering that in the States Parties to the Partial Agreement as well as in Austria, Norway, Switzerland, Spain and Portugal, legislative authorities and public and private enterprise have agreed to intensify their efforts to achieve the social integration of disabled people ;

Considering that more than 500 million people in the world are disabled as a consequence of physical, mental or sensory impairment ;

Recognising that the rehabilitation of disabled people as a means of securing their integration in working life and society is the duty of the community and a guarantee of respect for human dignity and should be included in their priority objectives in social policy ;

Recalling the principles stated in Article 15 of the European Social Charter : "The right of physically or mentally disabled persons to vocational training, rehabilitation and social resettlement" ;

Considering that failure to protect the rights of and foster opportunities for disabled citizens is an insult to human dignity and represents a heavy financial burden, and owing to this attitude :

— many people are allowed to become unnecessarily dependent and incapable of activity that is economically and socially productive ;

— the remedies to this dependence seem often only financial, whereas, in fact, compensatory benefits for the disability are but one aspect of a policy in favour of disabled people ;

Considering that it is important to ensure an early start to the continuous and comprehensive process of rehabilitation carried out by qualified personnel within a coherent, co-ordinated framework ;

Feeling the need to consolidate all past resolutions of the Brussels Treaty Organisation, of the Western European Union and of the Council of Europe in the field of rehabilitation and resettlement of disabled people,

Recommend that the Governments of the States Parties to the Partial Agreement as well as the Governments of Austria, Norway, Switzerland, Spain and Portugal :

— follow the principles and take into account the measures set out in the appendix to this resolution when drawing up their rehabilitation programmes ;

— ensure a wide distribution of this resolution in public and private circles dealing with the rehabilitation of disabled people ;

Resolve that this resolution replaces the following recommendations and resolutions :

— adopted under the aegis of the Brussels Treaty Organisation : the Recommendation on the policy on the rehabilitation of the disabled, adopted in May 1950 and revised in November 1958 ; the Recommendation on the training of personnel concerned with rehabilitation, adopted in May 1950 and revised in April 1959 ; the Recommendation on the rehabilitation and training of physically disabled children and young persons in relation to their placing in employment, adopted in April 1951 and revised in October 1957 ; the Recommendation on the rehabilitation of the tuberculous, adopted in November 1951 ; the Recommendation on general education, training and employment of the blind, adopted in November 1951 and revised in October 1957 ; the Recommendation on education and training of deaf children, adopted in May 1953 ; the Recommendation on rehabilitation of those suffering from the paralytic sequelae of poliomyelitis, adopted in April 1954 ; the Recommendation on rehabilitation of patients affected by cardiac rheumatism, adopted in October 1954 ; the Recommendation on conditions to be complied with by disabled persons for obtaining driving licences, adopted in October 1954 ; the Recommendation on statistics, adopted in October 1954 ; the Recommendation on the supply and manufacture of artificial limbs, adopted in May 1953 ; the Recommendation on sheltered employment, adopted in April 1955 ; the Recommendation on educational aspects of rehabilitation, adopted in April 1955 ; the Recommendation on the publicity measures designed to facilitate the rehabilitation and resettlement of the disabled, adopted in April 1955 ; the Recommendation on the rehabilitation and resettlement of epileptics, adopted in April 1955 and revised in October 1957 ;

— adopted under the aegis of the Western European Union : the Recommendation on the rehabilitation of the mentally disordered, adopted in September 1955 and revised in May 1960 ; the Recommendation on specialised transport for amputees and paraplegics, adopted in September 1955 ; the Recommendation on placing services for the disabled, adopted in April 1957 ; the Recommendation on means of locating disabled persons who, although in need of rehabilitation, have not so far had access to modern methods of treatment and training, adopted in May 1958 ; the Recommendation on the planning and equipment of public buildings with a view to making them more easily accessible to the physically handicapped, adopted in April 1959 ; the Recommendation on the rehabilitation of those suffering from brain injuries, adopted in May 1960 ;

— adopted under the aegis of the Council of Europe : Resolutions AP (60) 2, AP (63) 1, AP (63) 2, AP (65) 1, AP (66) 1, AP (66) 3, AP (66) 4, AP (66) 5, AP (67) 1, AP (67) 2, AP (69) 4, AP (70) 2, AP (71) 2, AP (72) 2, AP (72) 3, AP (72) 4, AP (72) 5, AP (73) 1, AP (74) 8, AP (76) 2, AP (76) 3, AP (76) 4, AP (77) 7, AP (77) 8, AP (81) 7, AP (81) 8 ;

Instruct the Secretary General to transmit this resolution to the Secretary General of the Western European Union.

Appendix to Resolution AP (84) 3

I. GENERAL POLICY

1. Principles

Member states[1] should intensify preventive action to :

— eliminate impairments, disabilities and handicaps ;

— put into operation a comprehensive and co-ordinated rehabilitation policy ;

— promote the full participation of disabled people in their rehabilitation and in community life.

2. General directives

2.1. *Goal and purpose of rehabilitation*

2.1.1. Rehabilitation concerns all areas of community life and is particularly directed towards the following aspects which should be smoothly co-ordinated and developed with the full participation of disabled people :

— prevention, identification and diagnosis of impairments, disabilities and handicaps ;

— treatment, fitting of appliances and functional or medical rehabilitation ;

— pupil and vocational guidance ;

— schooling ;

— vocational training and rehabilitation ;

— employment, sheltered employment, job assessment and placement ;

— technical and social aids, access to buildings, housing, communication, transport, leisure, sport and holidays ;

— training of staff involved in rehabilitation ;

— health education, information and research ;

— social counselling ;

— co-ordination of activities.

2.1.2. The principles underlying rehabilitation and the aims it pursues are as follows :

— to establish disabled people's right to integration and society's duty to achieve it ;

— to eliminate physical and psychological obstacles in society and enable disabled people to participate fully ;

— to recognise the need for early action in rehabilitation ;

— to see the value of rehabilitating as completely as possible disabled people with a view to their integration or resettlement, preferably in their social environment, should such be the case in their previous job or in suitable employment in their previous working environment ;

— to devise rehabilitation programmes which form a comprehensive, continuous, personalised process providing services from the onset of the impairment and moving on through successive stages until integration into working life and in society has been achieved ;

— to ensure close and early co-operation between the staff and institutions involved in rehabilitation, and to establish liaison between the agencies and authorities concerned with the rehabilitation and employment of disabled people.

2.1.3. The rehabilitation programme should include all measures to :

— prevent the appearance and aggravation of impairments, disabilities and handicaps and to eliminate or reduce their effects ;

1. For the purposes of this resolution, the expression "member states" means the States Parties to the Partial Agreement (Belgium, France, Federal Republic of Germany, Italy, Luxembourg, Netherlands, United Kingdom of Great Britain and Northern Ireland) as well as Austria, Norway, Switzerland, Spain and Portugal.

— prepare a disabled person to take up or resume a normal place in the community, particularly at work or in his ordinary social environment.

2.1.4. Rehabilitation should be viewed in general, collective and individual terms, and should be regarded as a comprehensive, continuous process, providing services aimed at social and work integration. The active and continuous co-operation of the disabled person himself is essential. It is of the utmost importance to combine, as early as possible, medical treatment and the various stages of medical and occupational rehabilitation in order to eliminate or reduce the impairment, the disability and handicap.

2.1.5. To this end, it is essential that rehabilitation should be viewed as a *coherent* process.

2.1.6. At the individual level, rehabilitation is a continuous process designed to avoid an impending disablement, to maintain, increase or restore the individual's capacity to engage in a normal activity.

In the context of a rehabilitation programme this process includes a variety of individual, complementary measures, applied simultaneously or successively :

— medical and physical measures,
— psychological measures,
— educational and vocational measures,
— social measures,
— rehabilitation into work.

2.2. *Impairment, disability and handicap*

In the context of health experience :

— an *impairment* is any loss or abnormality of psychological, physiological or anatomical structure or function ;

— a *disability* is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being ;

— a *handicap* is a disadvantage, for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural factors) for that individual[1].

2.3. *Methods to be adopted for the introduction and pursuit of the rehabilitation policy*

2.3.1. The advice and help needed by a disabled person before, during and after rehabilitation should be given in a co-ordinated manner. This co-ordination, which is indispensable, may take various forms according to national circumstances.

Methods should be adopted, in this regard, to enable each case to be followed and to ensure that there are no gaps in the provision of rehabilitation services, that the chosen occupation continues to be mentally, physically and professionally satisfactory to the person concerned, that he adapts to it progressively and that it leads to his social integration.

2.3.2. In the interests of effectiveness, it should be ensured, as far as possible, that optimal use is made of rehabilitation methods in establishments provided for the general public. If the need arises, specialised facilities and services should be set up in conjunction with public authorities, welfare associations and other organisations.

2.3.3. There should be consultations with experts and technical committees specialising in the various aspects of rehabilitation, and with advisory boards or organisations of, or for, disabled people.

2.3.4. As rehabilitation covers many fields, it is essential to encourage close co-operation between health, education, vocational training, employment, social welfare and all other relevant agencies and authorities.

2.3.5. Public and private agencies active in one or more of these fields should co-operate in implementing the programme.

2.3.6. To give the general rehabilitation programme unity of approach, purpose and action, each country should set up a *co-ordinating* procedure in order to establish the closest possible co-operation between the various agencies concerned with rehabilitation and employment, such as government departments, regional and local authorities, families, voluntary organisations of and for disabled people, and also between the various groups of staff directly involved in the work. Co-operation should be encouraged at national, regional and local levels.

1. The term "disabled person" ("personne handicapée" in French) is used in the general context of this resolution. The differentiation between "impairment", "disability" and "handicap" is useful to highlight the real impact of its provisions.

II. PREVENTION — IDENTIFICATION — DIAGNOSIS

1. Prevention

1.1. The most important measures for prevention should be put into effect as early as possible. These measures should include in particular :

— better nutritional practices, improved health services, early detection and diagnosis, pre-natal, perinatal and post-natal care, medical care for new-born infants, schoolchildren and workers ;

— proper instruction in health care and health programmes, education in healthy lifestyles, and on environmental hazards, family planning ; and

— the fostering of better informed and strengthened families and communities.

1.2. On account of the changing social and economic trends a new strategy should be devised to allow the introduction of measures to prevent occupational, traffic and domestic accidents and to promote early identification of a wide range of physical and mental disorders in order to reduce their severity or after-effects.

2. Identification

2.1. Particular attention should be paid to the need for early detection of :

— certain kinds of malformation (by means of national records) in order to determine their origin and eliminate them as soon as possible ;

— congenital and acquired disorders, in order to attenuate their effects or consequences as soon as possible by medical or surgical treatment, appliances and/or a rehabilitation programme involving the provision of appropriate personalised and continuous services ;

— failings due to advancing age, so that action may be taken to prevent their appearance or deterioration and enable old people to remain self-sufficient as long as possible in favourable material and psychological conditions.

2.2. Such detection, which should comprise means of identification through recourse to compulsory or voluntary reporting of cases, should be carried out in the interests of disabled people and requires the assistance of :

— the authorities and departments responsible for the provision of services and benefits ;

— the services responsible for the detection of impairments,

and, depending on the circumstances in each country, should be carried out on the occasion of periodic medical examinations before and after birth, during infancy, at school, before marriage, before and during employment or at other stages in life.

3. Diagnosis

3.1. The purpose of detection measures should be to permit an accurate and detailed diagnosis of the disorder or impairment observed in order to draw up a rehabilitation programme as soon as possible. Preventive medicine centres and medico-social services should help to establish a precise, accurate and early diagnosis.

3.2. Diagnosis should be based on investigations into the origin, nature, and extent of the disorder or impairment, in the light, in particular, of the family medical history.

III. ASSESSMENT OF APTITUDES — TREATMENT — FUNCTIONAL OR MEDICAL REHABILITATION — TECHNICAL AIDS — TRANSPORT

1. Assessment of aptitudes

1.1. It is essential to assess at the earliest possible stage, on the basis of the diagnosis, medical evidence and relevant expert opinion, the extent of the remaining mental and physical faculties or those which can be restored through rehabilitation, in order to reach the best possible prognosis of the person's occupational and social resettlement. At the time of making this prognosis and at all stages of the process, account should be taken of personal considerations as well as of the individual's educational and occupational history and social and family background. This requires a multidisciplinary approach and efficient co-ordination between the various professional disciplines involved.

1.2. The assessment of aptitudes and their probable evolution should be made :

— at the medical level by doctors specialising in rehabilitation, by other specialists with expertise in rehabilitation according to their speciality, or by doctors with special knowledge of particular disabilities ;

— in the field of vocational guidance, vocational training and employment, by specialists in this matter who are particularly knowledgeable regarding disabilities and their evolution, with a view to providing the most adequate prognosis.

1.3. The assessment of aptitudes should be regularly reviewed at all stages of rehabilitation, as well as when the individual takes up employment.

1.4. To make sure that services are effective, they should be provided free of charge.

1.5. There should be a sufficient range and number of centres or departments specialising in the assessment of physical and mental aptitudes to meet all needs and they should be equipped to use the most up-to-date investigation techniques.

1.6. The effectiveness of these measures and the coherence of the rehabilitation process demand co-ordinated action by the centres or departments responsible for detection, diagnosis and the assessment of aptitudes, and by other rehabilitation institutions.

2. **Treatment**

2.1. The combination of medication, diet, care and surgery in the form of an early, active and continuous programme based on modern technology and therapy should enable disabled people to benefit from all the resources available for rehabilitation.

2.2. To this end, attention should be drawn to the following points :

a. the crucial importance of making early stimulation and treatment available to children suffering from an actual impairment or who risk becoming handicapped, to ensure the full development of their natural capabilities and to limit as far as possible the impact of the impairment. Special attention should be paid to promoting the participation of the family in carrying out early stimulation and treatment ;

b. the need to advise a person on the best treatment for his impairment and on the possibilities of leading an independent life. Account should be taken of advances in medical and surgical treatment suited to the nature and severity of the impairment or disability ;

c. the importance of having sufficient numbers of specialists and/or hospitals equipped to provide treatment or services. If necessary, experienced foreign specialists and establishments should be consulted ;

d. the obligation to link rehabilitation requirements to the health programme in order to determine the criteria for recognising specialists and establishments for the treatment of disabled people and the rules according to which the latter must function ;

e. the advisability of providing for, and developing, possibilities of out-patient or home care where the disability permits it, or of keeping disabled people in their family and social environment, in order to enable them to live, as far as possible, an independent life ;

f. the need to set up specialised treatment centres for the optimum rehabilitation of people suffering from disabilities of specific types providing—in addition to medical treatment and technical aids—psychological assistance, occupational therapy, recreational activities and so on.

3. **Medical rehabilitation**

3.1. *Definition*

Medical rehabilitation is the whole range of specialised treatment and retraining designed to reduce the after-effects of the injury, disease or disability, restore physical or mental functions and develop or restore, even if only partially, the individual's capacity to pursue normal activity.

It includes :

— *functional rehabilitation* : the various multidisciplinary techniques likely to improve the functional prognosis of disabling local and/or general pathological conditions.

The last stage of functional rehabilitation, where appropriate, should include pre-vocational training or retraining for exertion.

— *medical and educational processes* : medical rehabilitation for children with all types of disabilities involves the use of special medical and educational processes.

3.2. With the introduction, growth and widespread adoption of medical rehabilitation it has become clear that, as a follow-up to actual medical treatment, it facilitates the integration of the disabled person in working life and society.

Early rehabilitation should allow, depending on the case :

3.2.1. *Children*

— to be educated, as a first preference, in an ordinary school and/or to attend a specialised day school to permit them to remain within the family circle ; or

— if they require residential care in a medical and educational institution—which should have a family atmosphere—to be spared hospitalisation wherever possible.

Where institutional care is unavoidable, the necessary help should be given to the disabled child's family to maintain contact with the child.

3.2.2. *Adults or old people*

— to avoid hospitalisation or to leave hospital sooner and to escape some of the disadvantages of a long stay in hospital. To this end, measures should be taken :

- to provide sufficient out-patient departments, specialised centres and day clinics providing out-patient treatment ;
- to facilitate transport to and from such establishments in order to enable them to benefit from this treatment. To enable the integration of disabled people into working life and society, services should as far as possible be provided at home or in out-patient clinics, and facilities should be set up accordingly. Where institutional care is unavoidable, arrangements should be made for the patient to return home at regular intervals. Developing facilities for moving about and modes of transport adapted to the specific circumstances and disabilities of the people concerned and their availability in sufficient numbers, is one way of introducing and promoting this approach to rehabilitation ;
- to arrange for people who find such visits difficult or impossible to receive home treatment from the team of specialists required to ensure their complete rehabilitation.

3.3. Prolonged hospital treatment can be avoided by the following measures :

3.3.1. *During the stay in hospital :*

— appropriate social action by the institutions themselves and by public or voluntary agencies to prepare and facilitate discharge from hospital, especially by establishing contact :

i. with the family, to ensure that they continue to take an interest in the disabled person ;

ii. with the employer, when work can be resumed ;

iii. with the landlord, to avoid loss of accommodation ;

iv. if need be, with a service concerned with making accommodation accessible.

— appropriate action to protect the patient's property during his stay in hospital and make sure that he retains his accommodation.

3.3.2. *After discharge from hospital :*

— devising all measures to assist the family to take (or take back) the disabled person to live with them on discharge from hospital ;

— securing the disabled adult's resettlement at work as soon as possible ;

— securing the disabled person's resettlement in society and the continuation of treatment.

3.4. To be fully effective, medical rehabilitation institutions, besides offering specialised care for specific types of treatment should provide :

— training or retraining for exertion ;

— psychotherapy ;

— standard occupational therapy and, for adults, occupational therapy prior to employment ;

— help for a person to adjust to his limitations with a view to overcoming his handicap.

In order that this phase may be fully effective, medical rehabilitation needs to be complemented by the availability of social counselling services.

3.5. Residential medical rehabilitation and medico-educational institutions should include among their general services leisure activities giving patients opportunities for contact with the outside world. Insofar as the care provided by all these institutions is concerned, they should be equipped with a maximum of technical rehabilitation facilities and staff or be able to call on a medical and paramedical team. For specialised care and treatment, they should make arrangements with specialised hospitals.

3.6. Employers, employers' organisations, occupational accident insurance agencies and similar bodies should be encouraged, to the extent required by national conditions, to set up medical and physical

rehabilitation centres or assist in setting up rehabilitation centres providing mostly medical treatment, occupational therapy and similar services to help employees to regain working fitness.

4. Technical aids

4.1. *General provisions*

4.1.1. The "medical rehabilitation" stage should also comprise all the steps taken to choose and fit the appropriate prosthetic or technical aids. Ensuring that the right appliance is acquired as speedily as possible ; its adjustment, maintenance and renewal are thus part of the individual's rehabilitation programme.

4.1.2. To this end, the necessary medical, technical and administrative arrangements should be made to enable all those who need them to be speedily fitted with suitable modern appliances.

4.2. *Specific provisions*

4.2.1. Close co-ordination should be established on a national level between the various authorities responsible for directing the manufacture and supply of artificial limbs and other technical aids. This could be achieved by the creation of a national commission on artificial limbs, made up of representatives of the ministries and other interested parties.

4.2.2. It must be realised that the fitting of suitable appliances allows many disabled children to attend an ordinary school, assists occupational resettlement and helps towards the social integration of disabled people.

4.2.3. Fitting an appliance is an integral part of medical rehabilitation and should be done by a specialised medical rehabilitation institution or, at its instigation and with its co-operation, on the prescription of a medical specialist.

4.2.4. It is extremely important to ensure that the specialist, either alone or in consultation with the specialised institution's rehabilitation team, decides on the type of appliance and the model best suited to the recipient, ascertains the latter's ability to adapt to it and specifies what special devices are needed in his particular case.

It should be remembered that the correction of the impairment or disability at the earliest possible stage, or the choice of the most suitable compensation for it, allows the disabled person to develop his personality more freely.

4.2.5. Technical and administrative measures should be taken to co-ordinate, for the benefit of all persons concerned, the principles of modern appliance-fitting, objective information and uniform decision-making on technical matters and prices.

4.2.6. Traditional technical aids as well as the whole range of medical appliances and individual or collective communication aids or compensatory appliances (for example pacemaker, wheelchair, specially fitted car) should be made available.

IV. PUPIL AND VOCATIONAL GUIDANCE

1. Definition

The purpose of vocational guidance is to determine the occupations suitable for the disabled person, taking into account his previous occupation, his personal aptitude and wishes, the special requirements of the occupations considered and the possibilities of the labour market. Vocational guidance concerns also those who are temporarily unable to work.

2. Purpose

Educational, occupational or social difficulties arising from a disability may require early and continuous rehabilitation measures to be preceded, accompanied or followed by pupil or vocational guidance in the direction which offers a person the best long or short-term opportunities for satisfactory resettlement.

General or special vocational guidance centres or services should be set up to provide a suitable vocational guidance system enabling disabled people to acquire a reasonable level of general education and choose an occupation in keeping with their knowledge, aptitudes and abilities.

3. Need for, and advisability of, specialised vocational guidance

3.1. Specialised vocational guidance is needed because :

a. equipment adapted to disabilities must be available ;

b. the staff must be trained in special assessment techniques and know about disabilities and their evolution.

3.2. Special vocational guidance centres or special facilities in general centres could be set up to advise disabled people on training for a suitable occupation.

3.3. With certain types of disability, the special centre or service should intervene in the course of medical rehabilitation after a sufficient period of observation and after stabilisation of the treatment under continuous medical supervision. A network of rehabilitation facilities could be created in accordance with need.

4. Nature of assessments

4.1. The decision whether to carry out special assessments and, if so, the choice of methods, depend on a person's age and educational and/or occupational status.

4.2. Each country should accordingly have enough general or specialised vocational guidance centres or services to meet its needs.

5. Staff

5.1. The vocational guidance team should include a guidance officer, a doctor and a social worker. Depending on its degree of specialisation and the purpose of the centre or service, it could be supplemented by other specialists such as a psychologist, a physiotherapist or a technical instructor.

5.2. The parents and/or the disabled person or his/her representatives should be associated with the process.

6. Co-ordination of rehabilitation measures

6.1. Where the educational or medical rehabilitation institution does not itself offer its pupils or patients vocational guidance, it must co-operate with the appropriate centre or service.

6.2. The collaboration of the vocational guidance centre or service is required for everyone admitted to a course of vocational training and rehabilitation.

V. SCHOOLING

1. Conditions

1.1. Compulsory education at public expense should enable disabled people as far as they can to achieve economic independence and contribute to their country's social development.

1.2. Education should be provided wherever possible in an ordinary school. To meet their specific needs, disabled children should be supplied with special therapeutic and educational aids.

Where education in a special school is necessary, provision should be made for close co-operation with the ordinary school and contacts with non-disabled children of the same age.

1.3. The aptitudes of disabled children of school age should be assessed before actual vocational guidance is considered.

1.4. As contacts between the special school and the child's family are essential, the family's interest in the work of the school or special centre should be stimulated.

2. Aim

2.1. The aim of schooling is to encourage the acquisition of the best possible level of general education and the development of appropriate vocational guidance and training with a view to better integration into society.

2.2. Care should be taken to bring about an adequate and effective improvement in the instruction and general education of disabled young people.

2.3. Pupils who are unable to attend school because of illness or disability should receive tuition at home or in special centres.

2.4. All disabled people who can benefit from it, should be given the opportunity of continuing their education.

3. **Ordinary education**

3.1. A proper assessment of the possibilities and aptitudes of disabled children, functional rehabilitation through non-hospital medico-therapeutic services and special educational support should enable the largest possible number of children to attend an ordinary school.

In nursery schools the education of disabled children side by side with other children should be based on tried and established models of integration.

3.2. Teaching in ordinary nursery schools and wherever possible in special nursery schools, likewise, should foster integration.

4. **Special teaching**

4.1. Children too seriously disabled to attend an ordinary nursery school should receive special tuition at an early age, either at home or at a special centre, such as a special nursery school.

4.2. A sufficient number of special schools and vocational training schools should be set up and staffed by teachers with adequate special teaching qualifications.

4.3. Day schools are preferable because they allow the child to remain in the family circle ; only where attendance at such schools is impracticable because of the nature or seriousness of the disability or for other valid reasons should children be placed in boarding schools.

4.4. Day and boarding schools should specialise as far as possible so as to give children an education suited to their particular disability.

4.5. Where residential care for children is essential, it should be provided in a family atmosphere. Children in boarding establishments must be able to see their families regularly.

To avoid prolonged absence of the child it may be desirable to place children in foster families. Contacts between them and their parents should be regular wherever practicable.

4.6. The appearance of psychological, emotional and behavioural disorders in disabled children can often be prevented by suitable educational and medico-therapeutic support, proper parent guidance and regular contact with able-bodied children.

4.7. Special schools for deaf and blind children should be equipped with collective aids and other mechanical devices.

4.8. Disabled children should be able to have special teaching either in groups or individually.

4.9. Special teaching should continue for as long as the disabled person profits by it.

5. **Education and rehabilitation**

5.1. Links should be established during schooling between education, occupational training and future employment by arranging for appropriate ordinary or specialised vocational guidance assessments.

Vocational guidance should be provided for ordinary school pupils as well as for pupils of medico-educational institutions.

5.2. While at school, children must have access to the various medical or functional rehabilitation resources.

5.3. Young people with disabilities and especially those who are retarded, should receive special educational support during their course.

5.4. Educational establishments should be easily accessible and structurally adapted to the needs of disabled children.

VI. VOCATIONAL TRAINING AND REHABILITATION

1. The rehabilitation programme should endeavour to set out and develop the concepts in the ILO Convention 159 and Recommendation 168 on vocational training and rehabilitation in order to further the integration of disabled people.

1.1. *Aim*

Vocational training and rehabilitation comprise the measures designed to enable disabled people, by means of appropriate training, to take up or return to an occupation thereby facilitating their social integration (appropriate because it is, or is not adapted, according to the case).

1.2. *Level and sectors of vocational training*

1.2.1. Vocational training should encourage the acquisition, particularly by young people, of the best possible level of general education, all-round training and technical or scientific skills.

1.2.2. Disabled people with suitable aptitudes should be given every opportunity to benefit from higher education.

1.2.3. Vocational training and rehabilitation should cover the widest possible range of economic, administrative and social sectors to give those who have been rehabilitated a better choice of occupation.

1.3. *Financial responsibility for vocational training and rehabilitation*

The cost of initial vocational training on account of disability and employment resettlement should be borne by public funds insofar as the funds are not supplied by employers.

The ways of financing decided upon should take account of the particular responsibilities laid upon employers concerning the training of their staff.

1.4. *Vocational training and rehabilitation instructors and institutions*

1.4.1. Ordinary training and rehabilitation courses should be available to those who are not too severely disabled to attend them.

1.4.2. Those with certain types of disability, or those whose residual aptitudes have proved during rehabilitation, especially at the vocational guidance stage, to be extremely limited, may require special vocational training and rehabilitation courses in special schools, medico-educational institutions or vocational training and rehabilitation centres for disabled people, or else special on-the-job training or rehabilitation.

1.5. *Disabled people's adjustment to vocational training and rehabilitation*

1.5.1. Vocational training and rehabilitation should accompany medical supervision of the disabled person in co-operation, if possible, with the centre or institution which provides functional or medical rehabilitation.

1.5.2. In each case periodical training or rehabilitation assessments should be made in co-operation with, or by, the vocational guidance centre.

1.5.3. Vocational training and rehabilitation should aim at helping the person in question to adapt to his disability.

VII. EMPLOYMENT, SHELTERED EMPLOYMENT AND ACTIVITIES AIMED AT RESETTLEMENT AT WORK

1. General policy on work and occupational activity

1.1. The general objectives of this policy should permit the fullest possible vocational and social integration of disabled people. This policy should promote their fulfilment, whatever the origin, nature and degree of their disability.

1.2. In application of this principle, all possible measures should be taken to enable disabled people to work in an ordinary working environment. This can be achieved either by normal employment, possibly subject to certain safeguards or by special measures, individual or collective.

1.3. Anyone who is so severely disabled that it is impossible for him to work in an ordinary working environment should be able to find a place, for some time or permanently, in adapted surroundings, for example :

1.3.1. sheltered employment in a sheltered workshop, at home or in an ordinary working environment.

Sheltered employment should :

— permit disabled people to carry out useful remunerative work suited to their residual capabilities and to benefit from vocational retraining which will allow them to find later on, whenever possible, an occupation in an ordinary working environment ;

— be reserved for people with disabilities who are for some time, or permanently, unable to fill jobs in an ordinary working environment ;

1.3.2. assistance through work centres, where they exist, which make provision for people who, because of their disability, cannot work in a sheltered workshop or in an ordinary working environment but are nonetheless able to carry out a remunerative rather than a purely occupational activity ;

1.3.3. centres of occupational activities in which people generally carry out activities without regard to productivity because of the extremely limited level of their functional capacities should :

— seek to develop the social, vocational and functional capacities of disabled people ;

— endeavour to prepare people for settlement in sheltered employment or in any other system of work.

2. Employment in a usual and ordinary working environment

2.1. *Conditions*

2.1.1. Disabled people should receive pay equal to that of any other worker for work of equal value.

2.1.2. Measures should be taken to facilitate, encourage and assist the settlement of disabled people in open employment. Such provisions are intended for persons who are judged to be fit for employment on completion of their rehabilitation process or though needing sheltered conditions of work, are capable of working in an otherwise ordinary environment.

2.1.3. Considerable attention should be given to the means that may be adopted in order to make integration into working life possible. Such means should include collective measures for the benefit of all disabled persons and special measures to solve individual integration problems. Full participation of the disabled person should be considered indispensable for his integration.

2.1.4. The authorities responsible for employment services should be provided with the administrative and financial resources to resolve the general or individual problems encountered in the occupational settlement of disabled persons.

2.1.5. The organisations of employers and workers as well as government departments and organisations of disabled people should be informed of these arrangements and be associated with the integration effort.

2.2. *Implementation and means*

Employment services or services responsible for the placement of disabled people should be able to take one or more of the following measures and to resort to one or more of the following means as required :

— collective measures :

- obligation to employ ;
- reserved employment ;
- employment incentives ;

— individual measures :

- contribution towards wages during the period of adaptation to the job by reason of the employee's disability ;
- adaptation of the job to the safety or operational requirements resulting from the employee's disability ;
- special tools dictated by the nature of the disability and special or adapted clothing ;
- means of controlling the lack of output and proportionate wage reduction with an eventual compensation by way of temporary aid, where the disabled person is unable, despite adaptation to the job, to keep up the normal pace ;
- other measures to offset exceptional expenditure arising from the employee's disability.

3. Measures to overcome the problems of occupational integration in sheltered employment

3.1. *General principles : concept and purpose of sheltered employment*

Sheltered employment should be open to persons who, because of their disability, are unable to obtain and keep a normal job in open industry.

Sheltered employment may be provided in a sheltered workshop, at home or in an ordinary working environment.

3.1.1. *Sheltered workshop*

3.1.1.1. A sheltered workshop should enable disabled people to have a useful and remunerative job.

3.1.1.2. It should allow the disabled person resettlement at work and should aim at his transfer to a normal occupation or to an ordinary working environment.

3.1.1.3. It should constitute a production unit independent of normal firms.

3.1.1.4. It should form part of the competitive economic system and should have its place in production.

3.1.1.5. It should offer satisfactory remuneration in relation to the type of work performed and as far as possible in accordance with conditions in open industry, and should bring the disabled person into the social security scheme.

3.1.1.6. It should endeavour to maintain a financial balance as far as possible and one which is compatible with its social purpose. This often involves a certain amount of assistance from the authorities and others, such as :

— help with construction,
— subsidy for running costs.

3.1.1.7. The prices of products and work performed should be competitive and not depend on the idea of charity.

3.1.1.8. It should be able to make or manufacture its own products or produce for firms under sub-contract.

3.1.1.9. It should make sure that its supervisory staff have the requisite technical qualifications and, if necessary, provide them for this purpose with additional information and training, having regard to the workshop's special role.

3.1.1.10. It should, as far as possible, establish with the disabled workers the legal employer/employee relationship.

3.1.1.11. It should make sure that the disabled workers it employs are given, as far as possible, work suited to their occupational capacities.

3.1.1.12. It should provide adequate supervisory staff under optimum social conditions.

3.1.2. *Employment under special conditions in open industry*

3.1.2.1. *Principles and purpose*

This type of employment should be reserved solely for people who, in spite of exploration of all the possibilities, cannot yet take up work in an ordinary working environment.

It should aim at enabling the disabled workers eventually to take up work in an ordinary working environment, if possible. For this purpose, the workers should be given special training.

As for working conditions, the situation of disabled people working in this type of employment should be assimilated as much as possible to that of other workers of the firm without prejudicing more advantageous conditions on account of the disability.

3.1.2.2. *Physical arrangements*

Whenever necessary, the sheltered employment workplace should have suitable entrance and exit facilities, ensure suitable working conditions and a working environment as normal as possible.

It should be situated in a place where workers do not, because of their handicaps, feel cut off from other workers.

3.1.2.3. *Control and supervision*

Sheltered employment should be subject to the general supervision of the competent authorities, which should cover :

— the suitability of the disabled person to be employed in such a system of work ;

— the legal status of the workers, the type of work, the working hours and the remuneration envisaged ;

— medical, social and psychological assistance to the workers ;

— special training and checks on workers' progress with a view to their complete settlement in an ordinary working environment.

3.1.3. *Work at home*
(See paragraph 5 below.)

3.1.4. *Work in an ordinary environment*
(See paragraph 2 above.)

3.2. *Implementation*

Measures should be taken by the competent authorities, if need be in co-operation with interested private bodies, to create, expand and maintain facilities for the training and sheltered employment of disabled people who are temporarily or permanently unable to cope with normal conditions of competition on the labour market.

4. Centres of occupational activities

4.1. *General principles : concept and purpose of centres of occupational activities*

4.1.1. A centre of occupational activities should be open to people who, because of their residual capacities, are not or not yet able to obtain or keep a job even in sheltered employment.

4.1.2. It should be able to provide occupation at the centre itself or in a person's home.

4.1.3. It should provide as far as possible for the psychological, medical, social and vocational adjustment of disabled people and contribute as much as possible to their transfer to sheltered employment or to any other system of work.

4.1.4. It should have competent medical, paramedical, educational and social welfare staff.

4.1.5. It should offer, as far as possible, occupational activities suited to the situation of the disabled people it serves.

4.2. *Implementation*

4.2.1. Measures should be taken by the competent authorities, if need be in co-operation with interested private bodies, to create, expand and run centres of occupational activities for disabled people who are temporarily or permanently unable to work even under sheltered employment conditions.

4.2.2. The creation or expansion of the concept of occupational activities aimed at furthering integration may be achieved by means of any of the following arrangements, bearing in mind the social situation and type of handicap of the people concerned :

— residential centres,
— semi-residential centres,
— day centres.

4.2.3. Centres of occupational activities should, if need be, allocate activities to be done at home by people who are unable to travel even with any assistance that may be available for the purpose.

5. Work at home

5.1. Work at home is justified in the case of people who, because of :

— vocational training and rehabilitation in preparation for self-employed activity ;
— their physical or mental, or their family situation ;
— geographical or local socio-vocational factors,

are unable to leave their homes or have serious difficulty in getting to work.

5.2. Work at home may be :

— performed in a self-employed capacity ;
— provided by the private and public sector ;
— organised by sheltered workshops ;
— supplied by centres of occupational activities, assistance-through-work centres or voluntary bodies.

5.3. If it consists of work for a firm or sheltered workshop, it should be useful and remunerative to the disabled person and bring him into a social security scheme.

5.4. Work at home entails the application of the following measures :

— in all cases : medical, occupational or social supervision ;
— if the disabled person is to be self-employed : the grant of financial aid at the time of installation.

6. Common and complementary measures to further the rehabilitation of disabled people in work

All measures should be taken and/or encouraged :

— to ensure that the rehabilitation agency follows up each case, sees that the job suits the person concerned, and where necessary suggests a change of occupation ;

— to co-ordinate action taken in this field and, wherever possible, incorporate it in the general framework of existing facilities and schemes for rehabilitating disabled people ;

— to see that the occupational activity of disabled workers is organised and carried out under the supervision of staff competent in matters of organisation, industrial economics, technical knowledge and personnel management and having tact and experience in dealing with disabled people ;

— to ensure that every disabled person undergoes regular medical examinations and that the medical report indicates the extent of the employee's disability and working capacity, with due regard to the type of

work and the conditions under which it has to be done, and that intensive industrial medical care, particularly directed towards rehabilitation, is available ;

— to ensure that disabled people working in sheltered employment or at home :

- earn a wage calculated on the basis of the rates applied to the same work done under normal conditions of employment ;
- are given the opportunity to increase their wages as well as their total income by their own efforts ;
- are entitled to an income which, as a rule, will provide them with a decent standard of living.

7. Contribution of employers and workers to the programme for rehabilitation into work and employment of disabled people

Steps should be taken to show employers and workers how they can contribute to the rehabilitation into work and employment of disabled workers.

Without prejudice to existing legal undertakings, such steps should be :

— to encourage, to the extent required by national conditions, employers, employers' organisations, autonomously or within the framework of the structures where they are represented, to create or help in creating special rehabilitation workshops, sheltered workshops or other types of sheltered employment ;

— to urge employers to sub-contract their production as appropriate to sheltered workshops or to disabled people working at home, and, if possible, to supply them with the necessary material and machinery ;

— to encourage employers generally to facilitate the rehabilitation of disabled workers by making suitable work available to them, if necessary after making adaptations to machinery or equipment and by giving them the opportunity to return to suitable types of employment as soon as they are medically fit for work, although not necessarily fit enough to resume their former occupation ;

— to encourage the development of occupational health services and arrangements for medical supervision in factories, which should, where possible, include among their functions the rehabilitation and resettlement of disabled people, and to promote co-operation between those engaged in such services and the various agencies working to the same end ;

— to draw the attention of workers and workers' organisations to the need to play an active part in the vocational rehabilitation and employment of disabled people.

8. The role of placement services

8.1. Employment services specialising in the placement of disabled people should function within the framework of the responsible placement organisms. They should be easily accessible to those concerned and their staff should be adequately qualified.

8.2. Specialised services should be able to settle disabled people, particularly those with certain types of needs, in all branches of the economy, as paid employees.

8.3. The standard of their staff should be constantly improved by all suitable methods, in particular through the best possible selection of placement officers, by providing training courses before or soon after they start work and also refresher courses, and by ensuring that they are well acquainted with the different types of work that can be offered to disabled people.

8.4. Where appropriate, follow-up action for as long as necessary should be taken by the placement services in collaboration with other services concerned to ensure that disabled people placed in employment are satisfactorily resettled in the economy.

8.5. In order to show exactly what results have been obtained, full and accurate employment statistics should be compiled, showing separately disabled workers placed directly and those placed after undergoing courses of rehabilitation or training.

8.6. In order to achieve the maximum efficiency through co-ordinated action, placement services for disabled people should either be a part of, or maintain the closest possible contacts with, the ordinary employment services and also with the various social and medical services concerned.

VIII. SOCIAL REHABILITATION AND INTEGRATION

Autonomy, independence, mobility, accessibility, communication, leisure and holidays

Whilst recognising that rehabilitation includes provisions to further the autonomy of disabled people and their integration in working life and in society, individual and collective measures should be included

and developed in the rehabilitation programme to ensure that they become independent individuals who are able to live as normal and complete a social life as possible, which includes the right to be different. Full rehabilitation means a variety of basic and complementary measures, provisions, services and facilities which can guarantee accessibility both physical and psychological. The adaptation of the urban environment and town planning, access to buildings and housing, transport, communication, leisure pursuits and holidays are factors which should all have a bearing on the goals of rehabilitation.

1. Social rehabilitation and integration of disabled people

1.1. The rehabilitation process should always take account of measures to further the disabled person's autonomy as an individual and/or ensure his economic independence and full integration in society.

1.2. Social counselling, social services, family help and guidance, and possibilities of participation by disabled people themselves and by organisations of and for disabled people should be furthered as basic conditions for attaining integration in full participation and equality.

1.3. Where the nature or severity of the handicap or the age of the person makes occupational resettlement impracticable even in a sheltered workshop, at home or in a special work centre, social, cultural and leisure-time occupations should be provided.

1.4. Specific arrangements should be made during the continuous rehabilitation process to give disabled people the greatest possible degree of independence, so that social and occupational integration problems may be faced at the earliest possible stage.

1.5. These arrangements should include, besides the most appropriate appliances for the disabled people, the availability of technical aids enabling them to pursue their daily personal and occupational activities safely, communicate, move about and engage in sport, cultural or leisure activities.

1.6. The relevant agency should advise disabled people on what is available in these respects in their own country, or, if necessary, on the purchase of suitable appliances or equipment abroad.

1.7. To ensure optimal resettlement, public authorities should provide, wherever possible, for the covering of the cost of such appliances or equipment as well as their maintenance and renewal.

1.8. These measures should be justified particularly in connection with the collective provisions listed below :

2. Collective measures

Because of the development of technical means to assist the autonomy and integration of disabled people, member states' domestic laws should take into account the following principles :

2.1. *Technical aids*

2.1.1. Besides the traditional or technical medical appliances designed to compensate the impairment or disability or offset its effects, a considerable range of technical aids is necessary or useful for daily professional activities.

2.1.2. The agency responsible for providing such aids should draw up a list of them so as to inform all the individuals and institutions concerned of their existence.

2.1.3. Particular care should be taken to determine the technical characteristics, prices and durability of each of the technical aids available on the market in order to establish what guarantees are being offered to the disabled users.

2.2. *Accessibility*

2.2.1. *General measures*

2.2,1.1. Measures should be taken in order to change people's attitude to the problems of disabled people, with optimum integration being accepted as a social requirement and a human right.

2.2.1.2. The scope of instruction and information given to people in the residential building sector should be widened to cover the problems outlined above and the ways of solving them. The closest co-operation with disabled people would be desirable to this end.

2.2.1.3. Regulations governing the construction of dwellings, public buildings, tourist and leisure establishments and installations used by the public should include basic standards for their adaptation to the needs of disabled people, such standards being taken into account when granting subsidies.

2.2.1.4. Housing policy should aim at autonomy in the life of disabled people, and to this end should :

— promote the accessibility of a large variety of housing accommodation : blocks of flats, family homes or community institutions of sheltered housing, etc. ;

— envisage adaptation measures for existing housing to cater for needs, and provide subsidies ;

— establish these provisions on the basis of education and information of architects and building constructors.

2.2.1.5. The access symbol devised by "Rehabilitation International" should be used for indicating the location of special facilities for disabled people.

2.2.1.6. The criteria set out in the technical note appended to this resolution on housing and public buildings and parking facilities should be taken into account in building policies.

2.2.2. *Transport*

Adequate transport facilities are essential in giving disabled people greater independence and choice in their lives. These facilities should be as flexible as possible to meet individual needs. Public transport, individualised transport and community-based transport schemes could all have a contribution to make towards improving disabled people's mobility.

Public transport

The public transport authorities should be invited :

2.2.2.1. to make possible or facilitate travel by disabled passengers, in order to promote their economic and social integration ;

2.2.2.2. in their plans for :

— designing or adapting means of public transport including infrastructures ;
— the building of transport vehicles ;
— the accessibility of these means of transport and vehicles,

to take into account the difficulties experienced by disabled people, and to this end, to ensure co-operation between the administrative departments concerned and organisations representing disabled people ;

2.2.2.3. to draw the attention of transport companies to :

— measures which could be taken at once to make possible or facilitate the use of public transport by disabled people and the importance of transport staff giving them assistance ;

— the difficulties and dangers which should be eradicated, reduced or avoided in the various public transport sectors ;

2.2.2.4. to promote the development of material or financial aid by public and private organisations for severely disabled people who are virtually unable to make use of public transport and who need to be transported.

2.2.3. *Special or adapted means of transport*

In order to promote out-patient rehabilitation, enable disabled people to live at home and assist those who have difficulty in using public transport because of the nature or severity of their disability, the relevant authorities in each member state should :

2.2.3.1. arrange for the provision according to need of the following equipment :

— two collapsible or non-collapsible wheelchairs (one for indoor, the other for outdoor use) for severely disabled people whose independence of movement is seriously restricted, wherever their physical condition so requires ;

— either a light vehicle, with or without a motor, particularly suited to the disabled person's condition or, wherever possible, and in preference to any other means of transport ;

— a car, and/or the essential adapted devices for regular use on the public highway, in the case of disabled people who have been medically certified fit to drive ;

2.2.3.2. ensure :

— that a medical specialist, either himself or in consultation with the rehabilitation team, decides what type of light vehicle and wheelchair is required by the disabled person, certifies the ability to drive a light vehicle or a car and specifies what devices are necessary for so doing, whether they be prostheses or special fittings for the car ;

— that whichever organisation provides or facilitates the purchase of the wheelchairs or the light vehicle, with or without a motor, assumes responsibility for the maintenance or replacement costs in accordance with current regulations ;

— that the same organisation encourages the purchase of the car by means of a financial contribution and assumes responsibility, in whole or in part, for the provision of special fittings to enable it to be driven safely by the disabled person for whom it is intended ;

2.2.3.3. make arrangements to issue a driving licence to disabled people provided that their ability to drive is established by a driving test, where necessary in a specially adapted vehicle ;

2.2.3.4. if they so desire, fix a speed limit for light motorised vehicles driven by disabled people because of the characteristics of this type of vehicle ;

2.2.3.5. consider the opportunities offered by door-to-door community-based transport schemes and the possibilities of involving disabled people in setting them up ;

2.2.3.6. encourage close liaison and an exchange of information at international level between national research centres concerned with improving special modes of transport adapted to the user's disabilities.

2.3. *Communication*

With a view to encouraging disabled people to participate as far as possible in the life of society, it would be desirable to adopt all measures allowing them to profit from means of communication : television, radio, press and telephone.

Among these measures the following examples may be mentioned : the subtitling of television programmes, induction circuits in public buildings, distribution of documents in Braille, the adaptation of call-boxes.

2.4. *Leisure, sport, holidays*

2.4.1. *Integration measures*

2.4.1.1. Social measures

2.4.1.1.1. Leisure time and holiday activities for disabled people should be integrated with ordinary leisure activities. Leisure activities for those with certain types of need could be organised in special clubs as a complement to ordinary leisure activities.

2.4.1.1.2. The participation of disabled people in all cultural, social, political and sports activities should be encouraged.

2.4.1.1.3. Sport should be recognised as one of the vital factors in the disabled person's rehabilitation, with particular respect to his integration into society.

2.4.1.1.4. Sports activities for disabled people should therefore be intensified and their further development encouraged by appropriate public relations methods, the training of staff, the planning of sports centres and the promotion of associations concerned with sports activities.

2.4.1.1.5. In accordance with the objective of rehabilitation, appropriate measures should be taken for practising sport in the company of the able-bodied.

2.4.1.1.6. Programmes for the training of leisure and holiday promoters should be adapted in order to allow disabled people to be trained for these careers.

2.4.1.2. Structural measures

2.4.1.2.1. Structural, technical and psychological obstacles which limit the enjoyment of leisure time, sport and holiday possibilities for disabled people should be removed ; in particular, access to buildings, to means of transport and to leisure establishments should be facilitated.

2.4.1.2.2. Disabled people's dwellings should be adapted to their needs in order to give them the possibility of spending their leisure time in conditions which are as normal as possible and in privacy.

2.4.1.2.3. Tourist establishments, sporting facilities and places of entertainment at holiday centres (cinemas, swimming pools, sports grounds, etc.), should be planned and equipped to render them accessible to disabled people.

2.4.1.2.4. Psychological barriers and other obstacles to communication between all people, whether disabled or not, should be overcome by means of material aids and through social programmes.

2.4.1.2.4.1. Material aids should include, amongst others, the technical means which enable disabled people :

— to take a full part in all leisure activities ;

— to communicate with the surrounding world through information systems (telecommunications, computers, etc.) suitably adapted to needs.

2.4.1.2.4.2. Social programmes, undertaken jointly by universities, private initiatives, organisations concerned with the rehabilitation of disabled people with particular kinds of need and public authorities, should also endeavour to :

— develop individual technical aids to compensate for the disability ;

— extend adaptations for accessibility to means of transport and communication.

2.4.2. *Information measures*

2.4.2.1. The general public, disabled people themselves and their families, and those providing services for disabled people should be informed of the existence of :

— technical aids and means of communication facilitating participation of disabled people in leisure, sport and holiday activities for all ;

— leisure and sport facilities, vacation possibilities and holiday resorts specifically adapted for disabled people if needed.

2.4.2.2. An international exchange of information should be encouraged on new initiatives to make it easier for disabled people to organise their leisure time and their holidays.

2.4.2.3. Tourist and leisure guide books should include all possible information on the facilities available for disabled people in tourist establishments (hotels, restaurants, etc.), on the accessibility of nearby leisure possibilities for them (swimming pools, cinemas, theatres, etc.) and on sport facilities. They should indicate by symbols the accessibility to and in hotels, restaurants and other tourist and cultural establishments. The key to the symbols should be given in several languages.

2.4.2.4. Tourist guide books for special categories of disabled persons could be envisaged whenever necessary preferably as a complement to normal guide books. Ordinary guide books could contain special information for particular kinds of disability.

2.4.2.5. National and/or regional information centres should provide disabled people and tourist offices and agencies with information on holiday, leisure and sports possibilities for disabled people at home and abroad.

2.4.2.6. Financial assistance should be envisaged to encourage initiatives to develop and improve tourist, leisure and sport information for disabled people.

2.4.3. *Other measures*

2.4.3.1. School curricula and physical rehabilitation programmes for disabled children should enable them to become aware of life in society as early as possible in order to motivate them for leisure activities as soon as possible and, if necessary, to adapt their choices to their skills and capacities.

2.4.3.2. Programmes for disabled adults should encourage them to undertake creative and leisure activities, even outside the institution, in order to enable successful social integration.

2.4.3.3. Scientific and technical studies should be carried out to examine more thoroughly specific problems concerning leisure time and holiday facilities for disabled people and, among others, the adaptability of leisure materials to their disability.

2.4.3.4. Specific sporting activities during the rehabilitation process should be planned, introduced or developed, particularly :

— when the nature of the impairment or disability calls for changes in the rules of certain sports, in the conditions under which they are practised or the equipment used ;

— when for psychological reasons, the disabled person has serious difficulty in practising sport with able-bodied people or feels the need for a reassuring environment created by and for disabled people.

2.4.3.5. The practice of sport during the rehabilitation process should be carried out under appropriate medical supervision.

2.4.3.6. The training of staff specialised in leisure, sport activities and holidays for disabled persons should be envisaged.

2.5. *Fiscal or tax facilities ; customs duties*

2.5.1. Disabled people should benefit from a reduction of, or even exemption from, tax when buying technical and prosthetic appliances, their accessories and spare parts which are necessary on account of their disability, in order to facilitate rehabilitation and integration to the utmost.

2.5.2. Identical measures should be adopted for customs duty when importing such objects.

2.5.3. Member states should consider gradually extending the possibility of abolishing or reducing such tariffs or duties to other types of technical and technological aids for disabled people.

IX. TRAINING OF STAFF

1. Principles

1.1. All those whose duties require them to take action in the technical or administrative areas of rehabilitation should be given adequate training, whether they are involved exclusively in the rehabilitation process or contribute to it through a medical, social or teaching activity.

1.2. The training of staff is to be understood in the widest sense.

1.2.1. It should embrace :

— general training, which normally leads to a diploma and forms the basic qualification for the work concerned ;

— specialised training in rehabilitation.

1.2.2. It should emphasise the following aspects :

— introduction or adaptation to the teamwork required by rehabilitation ;

— introduction to the technique of communication and teaching methods.

1.2.3. It should extend to :

— further training and in-service training ;

— retraining to keep up with technical advances in rehabilitation and technological advances in the various fields of social and economic activity.

1.3. To ensure that rehabilitation is seen as a personalised, single, continuous and co-ordinated process, occupational training courses should be guided by the same specific criteria as rehabilitation programmes for disabled people.

1.4. It is important that the standard of staff should be constantly improved, thanks to better selection, induction courses and further training courses.

1.5. Rehabilitation staff should be made thoroughly conversant with all the social and administrative measures that exist to assist disabled people and with the procedure for setting them in motion ; in particular they should be familiar with the different vocational guidance opportunities and the types of work which disabled people can be offered.

1.6. There should be very close co-operation between :

— the various staff directly involved in rehabilitation ;

— the various agencies concerned with rehabilitation and employment, such as national, regional and local authorities ;

— public and private agencies and voluntary organisations concerned with rehabilitation.

1.7. Co-operation between staff, authorities, institutions and voluntary organisations should be encouraged at national, regional and local level.

1.8. All available means of communication, both traditional and modern, should be used to achieve co-ordination.

2. Practical measures

2.1. *Training of medical students and doctors*

2.1.1. All medical students should be taught about rehabilitation problems, especially about the need for early diagnosis and treatment and for co-ordination between rehabilitation services and staff. For this purpose :

— rehabilitation should be a subject in the basic medical course ;

— knowledge acquired and performance in this field should be assessed.

In addition to the specific aspects mentioned under the heading "1. Principles", the teaching should cover the course of the impairment, disability and handicap, the general concept and process of rehabilitation, as well as methods of diagnosis, prevention and treatment, so that a patient can either be taken fully in charge by a doctor or be referred to a specialist. A sufficient number of teachers specialised in rehabilitation is indispensable for this course.

2.1.2. Doctors ought to acquire a thorough knowledge of rehabilitation, especially if they wish :

— to specialise in or devote themselves exclusively to rehabilitation since, whereas an impairment can be treated by any doctor, prevention and treatment in the case of a disability require specialised training and ability to co-ordinate, plan and evaluate a rehabilitation programme ;

— to enter a branch of social medicine (works doctors, social insurance doctors, doctors co-operating with vocational guidance services, child health surveillance doctors, etc.) ;

— to specialise in any branch of medicine involving rehabilitation (paediatrics, rheumatology, neurology, orthopaedics, cardiology, pneumology, etc.).

To the above end the following should be developed :

— specific training courses in multidisciplinary rehabilitation medicine and complementary integrated training courses adapted to each of the above-mentioned types of work ;

— structures combining medical care, teaching and research, particularly fundamental and clinical research, such as are necessary for the basic training of different practitioners and for retraining in the clinical, therapeutic and technological sectors, since on them all co-ordinated interdisciplinary action depends ; and such structures also as are essential for the training of senior medical care and teaching staff ;

— the dissemination of information and knowledge in this field backed up by the publication of basic texts and other works.

2.2. *Training of non-medical staff*

2.2.1. As regards non-medical staff :

— basic training courses should cover the concept and methods of rehabilitation and lay emphasis on the importance of teamwork, on patient-staff relations and on the need for the patient to take an active part in the treatment ;

— the training of senior staff for teaching and practice should be developed within the profession ; training should be integrated in the general medical system in order to facilitate the acquisition of a common language and to promote permanent contact and a process of "prescription—treatment—examination—evaluation" in the interests of the patient and of the staff ;

— in-service (particularly interdisciplinary) training schemes should be encouraged.

2.2.2. As regards student nurses and nurses :

— rehabilitation should be included in the basic syllabus of nurses' training courses, stress being laid on the need for active participation of the patient ;

— specific further training courses should be developed for certain categories of nurses, particularly :

- those working in specialised rehabilitation institutions ;
- those working outside hospitals, such as health visitors and district nurses, works nurses, school nurses, etc.

and for supervisory or teaching staff in or outside hospitals.

2.2.3. As a general rule, each member of the non-medical staff who, through his profession, collaborates in medical rehabilitation should be given a sufficient introduction to the subject and the opportunity not only to be kept informed of recent developments in his special branch but also in rehabilitation. This might be achieved by including rehabilitation in initial training courses or providing in-service training supplemented by special courses.

2.3. Steps should be taken to facilitate exchanges of rehabilitation staff between member states in order to broaden their knowledge of new methods and techniques.

X. HEALTH EDUCATION
INFORMATION : DISABLED PEOPLE - PARENTS - EMPLOYERS - PUBLIC
STATISTICS - RESEARCH

Rehabilitation programmes for disabled people should recognise :

— the importance of health education and of information, including statistics, in preventing impairments, disabilities and handicaps and assisting in rehabilitation as an individual and collective process ;

— that medical, educational, technological and/or scientific research plays a major role in promoting rehabilitation in its functions of prevention, improvement of the standard of services offered and achievement of optimum economic and social integration in modern society.

1. Definitions, health education and information machinery

1.1. All medical, social and educational activities relevant to rehabilitation should take account of health education.

1.2. The purpose of health education and information in rehabilitation should be to :

— prevent impairments as far as possible ;

— facilitate detection and direct disabled people towards the appropriate services ;

— inform them about the extent of the rehabilitation process ;

— encourage them to co-operate actively in their rehabilitation ;

— inform their families of existing rehabilitation facilities and develop their co-operation and understanding of disabled people's needs ;

— dispel prejudice against disabled people among the public, employers and other workers.

1.3. Since health education fulfils an important function which includes the need for general information on medical, social and educational matters, this chapter deals with information and health education measures.

2. Conditions of health education and information

2.1. Member states should support or publicise, through a co-ordinated health education and information system, the various opportunities for social and economic integration afforded by rehabilitation.

2.2. Health education and information departments and agencies should be organised in a coherent, co-ordinated manner.

2.3. A national health education and/or information centre should be set up to collect and distribute publications and information on the general and specific aspects of the programme for the rehabilitation of disabled people.

2.4. Scientific techniques should be used in the choice of health education and information themes and methods, and the assessment of the results achieved.

2.5. Specific aspects of health education and information which concern the various groups of disabled people should be studied in greater detail.

2.6. Great attention should be paid to the training of all persons liable to be concerned with health education and information by introducing into the courses offered to such people the study of general health education methods and specific points connected with the rehabilitation of disabled people.

2.7. All persons liable to be concerned with health education should be supplied with full and objective information and effective audio-visual aids.

2.8. The information media (press, radio, television, etc.) should be systematically used for health education purposes.

2.9. Progress in health education, information and publication of material should be supplemented by publicity in support of the rehabilitation of disabled people and its translation into concrete terms by their integration.

2.10. Among the above-mentioned means of publicising the main points of the rehabilitation programme, the use of statistics to supplement other information concerning impairments, disabilities, handicaps and rehabilitation should be included. Statistics should provide rehabilitation agencies with information for both internal and external use.

2.11. Information systems should be developed subject to appropriate legal safeguards for collecting complete and relevant data at both regional and national level on all categories of impairments, disabilities and handicaps in order to enable a realistic programme of assistance to be drawn up.

2.12. Knowledge about the type of data necessary (socio-demographic, administrative, medical, social, etc.) and the means of translating these data into indicators of needs should be developed and built into information systems to serve as a basis for the formulation of a policy. Within this context, it would be fitting to ensure that the measures cover the diverse needs of each category of people suffering from impairments, disabilities and handicaps.

2.13. When developing information systems, member states should aim at achieving comparability of data both at domestic and international level.

For this purpose, member states should :

a. develop the necessary co-ordinating machinery in order to ensure that information systems are built up and developed on the basis of common concepts ;

b. harmonise existing national systems ;

c. apply the provisions of their domestic laws regarding data protection, or in the absence of such provisions, take the necessary measures to protect the rights and interests of the persons concerned.

2.14. Data collection projects should be accompanied :

a. by the means to make the public, disabled people and all those concerned with their rehabilitation and welfare understand how important it is that they provide complete and accurate information ; and

b. by the means to make the aggregate data and results available to them.

3. Fields of health education and information

The application of the above-mentioned principles of health education and information should be extended to all the fields of community life with which rehabilitation is gradually becoming involved and should concern, generally or individually, disabled people, their relatives, rehabilitation technicians, employers and all agencies, institutions or organisations whose function is to provide services, co-operate in the rehabilitation programme or actively promote integration.

These fields cover :

3.1. *The cause and nature of disabilities*

3.1.1. The public should be informed about the nature and repercussions of disabilities. In this connection, it would be advisable to organise campaigns to inform the general public and make them aware of the problems and the potentials of disabled people.

3.1.2. Health education for all those involved in rehabilitation should concentrate on the specific problems raised by the disability in question and be backed by appropriate information and publicity methods.

3.1.3. The attention of the general public and of health staff should be drawn to the importance of early detection of incipient disorders or abnormalities which, if not dealt with in time, may result in long periods of impairment and diminished chances of rehabilitation.

3.1.4. The findings of surveys to determine the frequency of various disorders may prove extremely useful to the authorities responsible for planning health programmes.

3.2. *Prevention*

3.2.1. The public should be informed, for preventive purposes, about potential causes of impairments and disabilities and existing measures to reduce their effects.

3.2.2. Among the practical preventive measures applied, special attention should be paid to :

— the importance of prenatal consultations which should be made readily accessible to all pregnant women, for example by flexible arrangement of working hours and/or consultation times ;

— support for families with children suffering from chronic diseases who can be prevented from becoming disabled only by thorough and constant treatment. Technical and psychological support should be provided but in certain cases, financial aid should also be given if the treatment, whatever its type (diet, medication, etc.) is exceptionally costly and inadequately refunded by social security schemes. This support should be independent of any previous attribution of a disablement rate, which in any case is always difficult to determine for a child. This financial support should not increase the burden on public finance, as needs may no doubt be met merely by transferring certain sums without exceeding currently available resources.

3.2.3. Should malformations or disorders appear on a massive scale, an international exchange of information by way of statistics would pave the way for speedy concerted action to reduce their impact and prevent after-effects.

3.3. *Detection and identification of disabilities with a view to rehabilitation*

3.3.1. Public attention should be drawn to the importance of the early detection of abnormalities, diseases, injuries and disorders for the speedy initiation of the rehabilitation process.

3.3.2. To secure full, up-to-date information on disorders and disabilities as soon as possible, health authorities should store their statistical information in a uniform way so that it may be compared with that of other countries.

The circulation of the data thus collected should provide health or rehabilitation authorities and agencies with the information they need to draw up their programmes and plan rehabilitation facilities.

To this end, member states should :

— encourage for planning purposes the collection of statistics, indicating as far as possible the nature and severity of disabilities, not only their existence ;

— make use, in collecting statistics, of the findings of preventive examinations, school medical and psychological check-ups and periodical examinations ;

— make all those involved in rehabilitation, and particularly doctors, aware of the need for their voluntary co-operation in the detection of disabilities and the assessment of the disabled person's needs and abilities ;

— make the best possible arrangements for co-operation between detection and rehabilitation services and encourage the exchange of information on people in need of rehabilitation, bearing in mind that the utmost discretion should be exercised in the exchange of personal medical information ;

— give disabled people and those charged with their care technical and practical information on available detection and health care facilities.

3.4. *Rehabilitation and the techniques called for*

3.4.1. The introduction of a complete, uniform system of statistics should enable rehabilitation agencies to fulfil their information function towards :

— disabled people and all those charged with their care, by supplying technical and practical information on existing rehabilitation facilities and benefits ;

— all the individuals and agencies directly concerned or interested, by supplying them with regular lists of what is available, services and aids available in the various fields of rehabilitation, so as to build up an overall picture of the number, nature and structure of rehabilitation provisions, the services offered under the programme and the effectiveness of the means being used.

3.4.2. The information programme set up under this system should seek :

— to make disabled people themselves, their families, the working world and the general public sufficiently aware of the rehabilitation facilities that exist and what they can achieve ;

— to provide information about non-specialist rehabilitation techniques which can help overcome a disability and can be used, for example, by the person himself or his family ;

— to draw attention to observations on the application of the rehabilitation programme to specific types of disabled people ;

— to intensify efforts to supply information and documentation to all persons engaged in rehabilitation especially health care staff and social welfare and placement services ;

— to inform family doctors, school doctors, social workers and teachers of the facilities for physical and psychological assessment, treatment and special education available to children ;

— to keep all staff in charge of rehabilitation informed of progress in rehabilitation techniques and improvements in facilities ;

— to publish in each country a rehabilitation periodical of a sufficiently general nature to arouse the interest of the professionals concerned, disabled people and the public ;

— to improve the co-ordination of the information documentation and publicity work done by the various public and private rehabilitation agencies ;

— to encourage the various countries to exchange publications, leaflets, films or other material (at any rate, the most typical among them) produced for information or publicity purposes.

3.5. *Appliances*

Because of the rapid progress of orthopaedic techniques as regards both materials and limb-operating devices, exchanges of surgical, medical and prosthetic information and experience between central bodies in member states should be promoted and extended.

3.6. *Integration at school*

Health education and information should aim at :

— dispelling the fears and prejudices which teachers, classmates, parents and the general public might have concerning the integration of disabled children at school ;

— informing the public in general and teachers in particular of the advantages of integrating disabled children in an ordinary school environment ;

— informing teachers about the contribution they can make to the rehabilitation programme and the means they can use to this end.

3.7. *Rehabilitation into working life*

Health education and information in this area should seek to :

— dispel fears and prejudices among employers, fellow-workers and the public about the employment of disabled people ;

— inform the public in general, and employers in particular, including those in the public sector, of the advantages of resettling disabled people in working life ;

— solve the problem posed by the placement of disabled people, either by keeping employers constantly informed of the working capacities of rehabilitated employees or by notifying them of the steps taken by the authorities to impose obligations to employ disabled persons, offer incentives to employ or reserve certain jobs for them ;

— make clear to employers how they can help to rehabilitate disabled people and resettle them in employment ;

— inform employers about the contribution they can make to the rehabilitation programme and the means they can use to that end.

3.8. *Social rehabilitation*

The participation expected of the community in order to ensure the optimum integration of disabled people should call for the following measures with respect to information :

3.8.1. *Construction norms*

The basic structural norms which allow disabled persons access to buildings should be incorporated in building regulations.

3.8.1.1. *Buildings*

Faculties of architecture and town planning, building sector schools, employers' associations and building authorities should be informed of the measures called for to ensure and further facilitate access to :

— all buildings and facilities used by the public ;

— car parks.

3.8.1.2. *Housing*

Training courses and information for all persons involved in housing programmes should be extended to cover the study of access problems and their possible solutions.

3.8.2. *Transport*

3.8.2.1. Encouragement should be given to international exchange of suggestions, views and experience in regard to the nature of the vehicles to be made available to disabled persons and the means of control of such vehicles. This also applies to public transport and its accessibility to disabled people.

3.8.2.2. Vehicle manufacturers, disabled persons' organisations and rehabilitation agencies should be officially associated with this comparative study.

3.8.3. *Leisure, sport, holidays*

3.8.3.1. The general public, disabled people themselves and their families and institutions for disabled people should be informed of the existence of :

— technical aids and means of communication facilitating participation by disabled people in leisure, sports and holiday activities for all ;

— leisure and sports facilities, vacation possibilities and holiday resorts specifically for disabled people.

3.8.3.2. An international exchange of information should be encouraged on new initiatives to make it easier for disabled people to organise their leisure time and their holidays.

3.8.3.3. Tourist and leisure guide books should include all possible information on the facilities available for disabled people in tourist establishments (hotels, restaurants, etc.), on the accessibility of nearby recreation possibilities for them (swimming pools, cinemas, theatres, etc.) and on sports facilities. They should indicate by symbols accessibility for disabled people at hotels, restaurants and other tourist and cultural establishments. The key to the symbols should be given in several languages.

3.8.3.4. Tourist guide books for disabled people with particular needs could be envisaged whenever necessary, preferably as a supplement to normal guide books. Ordinary guide books could contain special information for groups with particular needs.

3.8.3.5. National and/or regional information centres should provide disabled people and tourist offices and agencies with information about holiday, leisure and sports possibilities for disabled people at home and abroad.

3.8.3.6. Financial assistance should be envisaged to encourage schemes to develop and improve tourist, leisure and sports information for disabled people.

4. Research

4.1. Steps should be taken to promote research into the problems posed by impairments, disabilities and handicaps and to collect the relevant statistics.

4.2. Close liaison and the exchange of information at national and international levels should be encouraged between research centres and services concerned with the rehabilitation of disabled persons.

TECHNICAL NOTE ON THE CRITERIA ON HOUSING, PUBLIC BUILDINGS AND PARKING FACILITIES

(see VIII, item 2.2.1.6)

1. Surrounding areas

1.1. The entrance at street level should be wide enough to permit the passage of wheelchairs.

1.2. Differences in carriageway and pavement level should be avoided as far as possible. If unavoidable, perpendicular differences in level of up to 2 cm are permissible. Greater differences should be eliminated by ramps complying with the following standards :

— from 2 to 9 cm, maximum gradient 1:5 ;

— from 9 to 37 cm, maximum gradient 1:8 (in this case, two handrails should be mounted to enable wheelchair users to pull themselves up) ;

— up to 75 cm, maximum gradient 1:12, preferably 1:20.

2. Housing and public buildings

2.1. Given the width of wheelchairs, the width of free passages should be at least 80 cm and preferably 85 cm (especially in the case of doors).

2.2. For dealing with indoor level differences, lifts should be installed, capable of receiving a wheelchair and of being operated by the wheelchair user. Doors and cages should be sufficiently wide (the cage should have a minimum length of 150 cm and a minimum width of 120 cm, the door of the cabin should be at least 90 cm wide ; at stops on each floor there should be an automatic levelling system so that the cabin is on a level with the floor ; the inside and outside doors should slide sideways automatically ; the outside and inside control panels should have the highest button at a maximum height of 120 cm from the ground ; an interphone system should be installed in the cabin in addition to the alarm bell and placed at a maximum height of 120 cm).

2.3. At the top and bottom of ramps there should be a level area of at least 150 cm in length.

2.4. Staircases should be straight with broad steps to allow the use of crutches. "Open" staircases should be avoided.

2.5. Handrails should be provided whenever possible ; on a very wide staircase a handrail should be put in the middle. They should be designed in such a way as to offer real support and an easy grip (maximum height 90 cm). A second handrail should be provided for children.

2.6. For blind people, who usually find their way by means of handrails, these should stretch the whole length of the stairs without any break at landings.

2.7. A wheelchair user wishing to get into or out of his chair by himself should be able to rely on such aids as handles, wall fixtures, etc. Independence in sanitary matters can be achieved by providing at least one toilet and bathroom with sufficient manoeuvering space and ensuring that support fixtures are installed properly and in the right places. Entrance halls and corridors should have a minimum width of 140 cm.

2.8. A wheelchair's turning-circle determines the manoeuvering space required in rooms, lifts and circulation areas. A complete turn requires a circle of a diameter of 150 cm. For lateral wheelchair movements a width of 140 cm should be available. The approach to a door in a side wall of a corridor calls for a minimum width of 140 cm. If a door is located at the end of a corridor there should be a minimum space of 50 cm between the door-frame and the side wall. An area of this size is absolutely essential in rooms with doors opening inwards.

2.9. There should be level entrances and non-slip covering for staircases, ramps and corridors.

2.10. The lower shoulder level and the greater pelvic fixation caused by the wheelchair-user's sitting position reduce both his horizontal and vertical range, the latter being between 30 cm and 140 cm above floor level. Therefore switches and other controls should be between 70 and 140 cm, preferably 90 cm above floor level.

2.11. Since a handicapped person's knees and the arm-rests of a wheelchair are at fixed levels, the lower surface of work tables or draining boards should be at least 68 cm and the upper surface 80-85 cm above floor level. For a right-angled approach to cupboards and refrigerators, etc., the space available for footrests should be at least 15 cm deep and 30 cm high.

2.12. The lower eye level of a wheelchair user when seated places limitations on the height of windows and of the solid portions of balcony balustrades, etc.

2.13. Provisions for an alarm system should be made.

2.14. Part of all housing accommodation should be designed so as to be easily adaptable to the needs of disabled people, without structural changes being necessary.

3. **Special measures for certain public buildings**

3.1. In post offices, theatres, banks, stations, etc., there should be outside or inside counters at an appropriate height for wheelchair users.

3.2. At booking offices there should be sufficient space between ticket windows and barriers : in stations, sports grounds, etc. there should be sufficient space at the exits.

3.3. In cinemas, theatres, etc. there should be room for people in their own wheelchairs.

3.4. In public baths there should be facilities specially designed to meet the needs of wheelchair users.

3.5. On staircases, ramps and in corridors in primary and secondary schools, provision should be made for a lower handrail at a height proportionate to the average age of the users, in addition to the normal rail at the standard height of 90 cm. In order to meet with the special problems of persons suffering from an ocular or aural impairment, sound and light signals should be installed for their guidance.

3.6. Telephone booths in all buildings and facilities accessible to the public should be sufficiently wide (minimum 120 × 120 cm) and the telephone should be on the wall opposite the entrance at an appropriate height (a maximum of 90 cm above the floor).

4. **Parking facilities**

4.1. In public car parks and parking lots on the public highways, areas should be set aside for cars designed for use by disabled people. There should be enough space for a wheelchair to be got out of the car (minimum width 3 m divided into two functional areas : the first with a minimum width of 170 cm for the space taken up by the car and the second with a minimum width of 130 cm to permit the wheelchair user to move freely when getting into or out of the car).

4.2. The area of the car park set aside and the disabled people's disability-adapted cars should display the appropriate international sign.