COUNCIL OF EUROPE
COMMITTEE OF MINISTERS

RECOMMENDATION No. R (92) 6

OF THE COMMITTEE OF MINISTERS TO MEMBER STATES
ON A COHERENT POLICY FOR PEOPLE WITH DISABILITIES

(Adopted by the Committee of Ministers on 9 April 1992 at the 474th meeting of the Ministers' Deputies)

The Committee of Ministers, pursuant to Article 15.*b* of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members for the purpose of facilitating their economic and social progress;

Considering that this aim can be pursued, *inter alia*, by the adoption of common rules in the field of rehabilitation;

Considering that there are in the world more than 500 million people with disabilities as a consequence of physical, mental or sensory deficiencies;

Recognising that the rehabilitation of people with disabilities, by virtue of the economic and social integration it achieves, is a duty of the community, which guarantees human dignity and alleviates the difficulties stemming from society with which people with disabilities are confronted, and that it should be included among the priority objectives of any social policy;

Considering that failure to protect the rights of citizens with disabilities and improve their opportunities is a violation of human dignity and entails a heavy financial burden, an attitude that results in:

– many people becoming unnecessarily dependent on others and incapable of any economically and socially productive activity;

– the remedies to such dependency often seeming only financial, whereas payments intended to compensate for incapacity are but one aspect of any policy in favour of people with disabilities;

Having regard to the fact that in member states the legislature as well as private and public initiative, particularly through the action of non-governmental organisations, have agreed to intensify their efforts to promote the social integration of people with disabilities;

Bearing in mind the principles embodied in Article 15 of the European Social Charter, *viz* the right of people with physical or mental disabilities to vocational training, rehabilitation and social resettlement;

Bearing in mind Recommendation No. R (86) 18 on the European Charter on Sport for All: disabled persons;

Considering it important that the comprehensive and continuous process of rehabilitation should be initiated very early and carried out by qualified personnel within a coherent and co-ordinated system;

Having regard to Resolution AP (84) 3 on a coherent policy for the rehabilitation of disabled people, adopted in the framework of the Partial Agreement in the Social and Public Health Field;

Having regard to the final declaration of the *ad hoc* Conference of Ministers responsible for Policies on People with Disabilities (Paris, 7 and 8 November 1991), inviting the Committee of Ministers to adopt the draft recommendation which updates Resolution AP (84) 3 and adapts it to progress made in the meantime,

Recommends that the governments of the member states:

– follow the principles and take measures advocated in the appendix to this recommendation when drawing up their rehabilitation programmes;

– ensure a wide distribution of this recommendation among public and private circles concerned with the rehabilitation of people with disabilities;

– provide a periodic stock-taking in the form of an update of the report on legislation concerning the rehabilitation of people with disabilities, including illustrations of concrete results achieved;

Resolves that this recommendation shall replace Resolution AP (84) 3.

Appendix to Recommendation No. R (92) 6

I. General policy

1. *Principles*

A coherent and global policy in favour of people with disabilities or who are in danger of acquiring them should aim at:

– preventing or eliminating disablement, preventing its deterioration and alleviating its consequences;

– guaranteeing full and active participation in community life;

– helping them to lead independent lives, according to their own wishes.

It is an ongoing and dynamic process of mutual adaptation, involving on the one hand people with disabilities living according to their own wishes, choice and abilities, which must be developed as far as possible, and on the other hand, society which must demonstrate its support by taking specific and appropriate steps to ensure equality of opportunity.

2. *Aims*

All people who are disabled or are in danger of becoming so, regardless of their age and race, and of the nature, origin, degree or severity of their disablement, should have a right to the individual assistance required to enable them to lead a life as far as possible commensurate with their ability and potential. Through a co-ordinated set of measures they should be enabled to:

– be as free as possible from avoidable impairments and disabilities;

– be as free as possible from needing permanent medical treatment and care, while having access to such care whenever necessary;

– retain as much personal responsibility as possible in the planning and implementation of rehabilitation and integration processes;

– exercise their rights to full citizenship and have access to all institutions and services of the community including education;

– be as free as possible from institutional settings and constraints, or where these are unavoidable, to have as much personal choice as possible within the said institution;

– have as much economic independence as possible, particularly by having an occupation as highly qualified as possible and a commensurate personal income;

– have a minimum livelihood, if appropriate by means of social benefits;

– have as much mobility as possible, and access to buildings and means of transport;

– be provided with the necessary personal care, in a location of their choice;

– have as much personal self-determination and independence as possible, including independence from their own families, if they so desire;

– to play a full role in society and take part in economic, social, leisure, recreational and cultural activities.

The special situation faced by women and elderly people with a disability should receive particular attention.

3. *Fields of intervention*

States must therefore pursue a coherent, global and comprehensive policy in co-operation with people with disabilities and the organisations of and for them, to secure all necessary help for people with disabilities. This policy concerns all areas of community life and is particularly directed towards:

– prevention and health education;

– identification and diagnosis;

– treatment and therapeutic aids;

– education;

– vocational guidance and training;

– employment;

– social integration and daily environment;

– social, economic and legal protection;

– training of persons involved in the rehabilitation process and in the social integration of people with disabilities;

– information;

– statistics and research.

4. *General directives*

To implement this policy states should take the following steps:

– guarantee the right of people with disabilities to an independent life and full integration into society, and recognise society's duty to make this possible;

– recognise the need for early intervention;

– prevent the onset and aggravation of impairment, disability or handicap, eliminate or reduce their effects and prevent the occurrence of additional handicaps such as emotional and psychological disorders;

– draw up in collaboration with the person with a disability and his family a rehabilitation programme involving a wide-ranging, continuing and personalised set of services, beginning as soon as an impairment becomes apparent, passing through successive stages to integration in working and community life and avoiding also the necessity for permanent institutional care;

– secure access to these programmes for all people with disabilities who need them;

– make optimal use of rehabilitation methods whenever possible, in establishments provided for the general public, and if the need arises, in specialised facilities and services;

– remove wherever possible all obstacles in the environment and in society and make it possible for people with disabilities to play a full role;

– ensure that people with disabilities have access to general or specialised education, according to their needs;

– ensure that people with disabilities enjoy a respectable standard of life, if necessary by means of economic benefits and social services;

– ensure access to leisure and cultural activities;

– involve the general public, professionals, social partners and the families of people with disabilities in their efforts;

– promote research on disability prevention, rehabilitation, and in other fields concerning people with disabilities;

– make sure that there is early and close co-operation between health, education, vocational training, employment, social welfare and all other relevant agencies and authorities and establish links and co-ordinating procedures between bodies, departments, regional and local authorities, families and voluntary organisations concerned with the integration of people with disabilities;

– improve the information of policy-makers whose decisions concerning the physical and social environment affect the quality of life of people with disabilities;

– encourage a wider distribution of information about the rights of people with disabilities and the services available to them;

– ensure that people with disabilities and their organisations play a full and active role in the promotion of these people's interests;

– set up a continuous evaluation process of measures taken on rehabilitation.

Moreover, integration of people with disabilities is a task not only for the state but for society as a whole and for all its members, representatives and institutions. Consideration for people with disabilities must not only be the responsibility of the family, friends and neighbours but of all members of society who must be mindful of all types of intolerance and who must realise that they too have a duty to enable people with disabilities to participate in life "as normally as possible".

The more it is accepted that people with disabilities must be integrated into the general and normal activities of life, the better external assistance – usually provided by the public authorities – can be concentrated on areas in which "automatic" participation by people with disabilities is not yet possible. Social security benefits and other assistance cannot replace, but only facilitate and further the integration into society of people who are, or who may become, disabled. Where, as a result of commitments by individuals and society, integration is achieved directly, the volume of "necessary assistance" is also reduced. However, it is important to ensure that sufficient financial resources are available in order to overcome the disadvantages affecting people with disabilities.

Social provisions remain, however, in many spheres an essential means of either activating and supporting self-help or initiating and promoting rehabilitation and integration processes. In addition, the more integration and independent living of people with disabilities in the community is a success, the more urgent is the need for:

– national, regional, local and individual co-ordination of all relevant activities by suitable structures with specific competences; and

– information for people with disabilities, their families and all the institutions involved in their integration, including advice on how best to take advantage of the facilities and assistance available in each case.

5. *Definitions*

5.1. The concepts underlying this policy are those defined by the World Health Organisation, namely:

– an "impairment" is any loss or abnormality of psychological, physiological or anatomical structure or functions;

– a "disability" is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner of 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.

5.2. It follows from this that the handicap depends on the person's relationship with his environment. A handicap is evident when such people encounter cultural, material or social obstacles, denying them access to the whole range of services and opportunities available to their fellow citizens. Thus the handicap involves the loss or limitation of scope to participate in community life on an equal footing with others.

5.3. People with disabilities do not form a uniform group of people all needing the same assistance. Definitions and classifications must therefore not have the effect of separating people with disabilities from society or excluding them from the possible steps of rehabilitation and integration, but point to their individual problems and prospects and to ways in which all people with disabilities can gain access to the assistance they need to enable them to participate fully in society.

II. Prevention and health education

1. *Aims*

Preventive action should be taken as early as possible in the individual, medical, occupational and social spheres as well as in the improvement of the surroundings:

- to prevent an impairment from arising or worsening;
- to reduce as far as possible the degree of disability for a given impairment;
- to reduce any social disadvantage arising from a given disability.

2. *Prevention of impairment*

2.1. To act against direct or indirect causes of impairments, strategies should be devised for appropriate action for the prevention of accidents (occurring, for instance, in the home, on the roads, on the sports field, at school and at work) and diseases (including occupational diseases, diseases associated with leisure activities, diseases common in elderly people, etc.). This action should comprise monitoring at various stages during the period of growth, regular check-ups for workers at risk, immunisation, and monitoring of degenerative diseases of adults and the elderly.

2.2. The health services should be capable of providing early diagnosis and treatment of impairments. In this context, the important role played by emergency medicine in the rapid and effective treatment of all health problems caused by accidents and for other reasons should be recognised and adequate financing resources, staff and training should be made available.

2.3. To prevent congenital impairments, services should be set up to provide genetic screening, pre-marital screening and diagnosis, monitoring of high-risk and normal pregnancies and confinements, care for high-risk new-born babies and early detection and diagnosis of diseases as well as mental, motor and sensory disorders.

2.4. The prevention of congenital impairments must always be in accordance with ethical principles. In particular, pre-natal genetic screening and diagnosis require that couples and pregnant women be fully informed and advised about the possibilities of and the reasons for their use, as well as about the risks they involve. Appropriate genetic counselling must provide pregnant women with full information, on the basis of which they may freely take their decision regarding these tests and must always accompany the pre-natal screening and diagnosis but not involve any compulsion.

3. *Prevention of disability*

In addition to the measures to detect, treat and diagnose impairments at an early stage, steps should be taken to ensure individualised and community programmes of rehabilitation, including follow-up and evaluation, as well as the necessary support to individuals and their families. These programmes should take account, *inter alia*, of each individual's specific situation and problems, with the help of functional diagnosis, in order to prevent any secondary (emotional, cognitive, mental, motor or social) effects of the impairment with the help of early educational measures targeted at the individual and the creation of awareness in the family and the sector of society concerned.

4. *Prevention of handicap*

Along with the steps recommended to prevent impairment and/or disability, individualised programmes of psycho-social rehabilitation aiming at the full development of the person should be set up. In addition, all necessary and adequate (also binding) measures should be used, as well as adequate measures to provide information, so as to promote the full integration of people with disabilities into society, *inter alia*, by means of early integration at school, provision of adapted educational services, integration into ordinary working life, etc., to enable them to live an independent life.

5. *Health education*

5.1. Health education should aim at helping people to develop the ability to take reasonable decisions regarding their own health and comprise all information and educational activities to encourage them:

- to lead a healthy life;
- to learn what to do – both individually and collectively – to remain in good health; and
- to avail themselves of assistance in case of need.

Within the framework of a coherent policy for people with disabilities, health education of individuals, the community, society and those members of society responsible for decision-making and management is an effective and indispensable preventive instrument.

5.2. Educational action intended to prevent impairment should be aimed at the whole population, and primarily at young people of school age, that is, at a time when children from all backgrounds are still particularly open and amenable to the reception of simple but effective messages concerning health education.

Action in regard to specific problems should be aimed at certain specific groups such as women of child-bearing age, couples, drivers and the elderly.

Consequently, the information which has to be given should relate to factors and circumstances which may give rise to impairment, such as:

– factors which stimulate congenital malformation (chemical, radioactive, biological and pharmacological agents, infection organisms);

– adverse effects on the foetus as well as cerebral lesions;

– growth deficiencies;

– certain pathological conditions;

– risks associated with lifestyles, for instance smoking or drinking;

– the process of ageing;

– circumstances which are the cause of accidents or which can lead to accidents.

5.3. Where there is an impairment, health education may be useful to prevent or limit a disability. The educational action should be aimed at the people suffering from the impairment, their families and all those – the general public as well as professional staff – who may be concerned.

The information to be provided should concern the situations and types of behaviour which give rise to disability, the measures which may be taken, use of the health services and the lifestyle of the individuals and their families. Elderly ill people should be made aware that in many cases:

– their condition is not irreversible if modern medical and psychological measures are applied; and

– the combination of therapeutical measures and personal determination can change their situation.

5.4. Health education directed to prevent impairments or disabilities from becoming handicaps extends to the whole of society and may promote the concepts of integration and rehabilitation, of equality of opportunity and of participation for people with disabilities.

Educational action should aim at:

– informing people with disabilities, their families and the general public how and why disability can lead to handicap, and how handicaps may be prevented or limited;

– meeting individuals' needs for independence and personal development in everyday life, work, schooling and recreation;

– contributing to the creation of individual and collective attitudes which can make life easier for people with disabilities;

and should make it possible to start a dialogue and foster solidarity between people with disabilities and the able-bodied.

III. Identification and diagnosis

1. *Identification of impairments*

1.1. In-depth studies are important to identify the nature and prevalence of conditions such as:

– certain impairments, in order to conduct research into their origins and eliminate their potential causes;

– certain congenital or acquired disorders, in order to attenuate their effects as early as possible through medical treatment or surgery, prostheses and orthoses or rehabilitation programmes in a continuous process of treatment adapted to individuals' needs;

– impairments due to advancing age, in order to prevent their onset or deterioration and enable elderly people to maintain their independence as long as possible in satisfactory economic and psychological conditions.

1.2. This study will rely heavily on periodical medical examinations, before and after birth, in infancy, at school, before marriage, before and during employment and at other stages of life, in full respect of medical confidentiality and of the right to privacy.

2. *Diagnosis*

A diagnosis of the impairment should be made as soon as possible, and be based on an accurate personal and family medical history, laboratory tests and a functional assessment of the exact nature and degree of the impairment. Measures should be taken to protect these data.

It would be appropriate to entrust responsibility for diagnosis to the existing preventive medical services and/or the medical and welfare services responsible for screening.

These services should also be responsible for collecting data on the cases examined, these being useful for devising preventive measures, and for ensuring confidentiality.

IV. Treatment and therapeutic aids

1. *Medical treatment*

1.1. *In order to prevent, eliminate or reduce the effects of impairments or disabilities, to prevent deterioration or to* alleviate their consequences at an early stage, it is necessary to implement an operational health programme of:

– competent therapeutic, especially surgical, medical, psychological and dietetic treatment, within a broad multidisciplinary and co-ordinated network;

– constant monitoring of the impairment with full respect for the freedom of the individual; and

– identification of the most suitable modern facilities for carrying out the programme adapted to the nature and seriousness of the impairment and disability concerned.

1.2. Early therapeutic action should be taken to limit the effects of the impairment as far as possible in order to ensure that:

– physical and other functional abilities will be regained and continue their natural development; and

– the need for constant nursing is avoided or reduced, especially in the case of elderly people.

1.3. People who are disabled or likely to become so and their families must be fully informed and involved, where possible, in the choice of treatment for their impairment and the choice of means of living an independent life.

2. *Medical assistance, medical and functional rehabilitation*

2.1. Health policy should cover all forms of medical and pharmaceutical assistance, including medical and functional rehabilitation.

2.2. Medical assistance services should include general medical and nursing assistance at home and on an out-patient basis, specialised medical and nursing assistance for physical and mental illnesses and hospital care. To ensure that people with disabilities have the benefit of comprehensive, extensive medical and psychological assistance services, special forms of assistance, as an out-patient or at home, should be available in preference to care in hospital, when the disability so permits, so as to improve the patients' quality of life and enable them to remain surrounded by their family and in contact with their friends.

Moreover, appropriate measures should be taken to provide social security cover for irreducible chronic pain, whenever necessary.

2.3. To ensure that people with specific types of impairment can be rehabilitated to the greatest possible extent, it is necessary to make provision for suitable treatment and, where necessary, to take advantage of the experience of specialists and hospitals in other countries.

2.4. Sickness insurance schemes should make provision, in the case of people with disabilities, not only for medicines normally used to treat acute illness and dangerous and chronic diseases but also for products which are primarily preventive.

2.5. Medical rehabilitation should comprise a combination of forms of treatment and specialised rehabilitation systems designed to lessen the consequences of the injury, disease or infirmity and restore the physical and mental functions.

Whatever the nature and degree of the impairment, the medical treatment involves psychological and educational support to adapt to the disability. The ultimate, essential aim is to assist people with disabilities to become as independent as possible.

2.6. Functional rehabilitation as an interdisciplinary combination of techniques for improving the functional prognosis and the prognosis for disabling localised or general pathological effects should include:

– motor rehabilitation, in which physiotherapy is used to enable the person to recover the use of the affected muscles and strengthen those that are intact;

– occupational therapy, in which the restored motor capacity is exploited and consideration is given to the possibility of using aids to enable the person with disabilities to learn or recover, as far as possible, all the functional activities needed to go back to work or find a job;

– rehabilitation of the capabilities needed to live an independent life in the community;

– rehabilitation to avoid or to reduce the need for continuous care;

– speech therapy, in which a person is given the opportunity to restore and develop communications skills.

2.7. Rehabilitation of children should take place early enough for them to develop fully their natural abilities and, in addition to functional rehabilitation, benefit from education, preferably in normal schools in the company of other children of the same age. As far as possible, preference should be given to out-patient treatment. If, however, hospitalisation or special institutional care is essential, strong, active links should be maintained with the school so that the children continue to mix with their peers. In addition, provision should be made for the aid needed to enable parents to maintain frequent contact with their children.

The child may often require both mainstream education and specialised care. These should be combined to facilitate transition and integration into normal school life.

2.8. For adults, including elderly people, measures should be taken to avoid hospitalisation or shorten hospital stays by:

– ensuring that sufficient specialised centres and clinics provide out-patient treatment;

– providing transport to and from such establishments in order to enable people to benefit from the treatment available;

– arranging home treatment where hospital visits prove difficult or impossible.

2.9. To enable the integration of people with disabilities 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.

2.10. Prolonged stays in hospital can be avoided by appropriate action on the part of the institutions themselves and by public or voluntary agencies to prepare and facilitate discharge from hospital, especially by establishing contact:

– with the family to ensure that it continues to take an interest in the person with a disability;

– with the employer when work can be resumed;

– with the landlord to avoid loss of accommodation;

– if need be, with a service which can make accommodation accessible;

– with those who provide social assistance services, upon hospital discharge, to facilitate the transition process.

It is also necessary to protect the patient's property during his stay in hospital and make sure that he retains his accommodation.

2.11. After discharge from hospital, all necessary measures should be available:

– to assist the family to take (or take back) the person with a disability to live with them on discharge from hospital;

– securing resettlement at work for the adult with a disability as soon as possible;

– securing resettlement in society for the person with a disability concurrent with the continuation of treatment, thus facilitating the transition process.

2.12. Rehabilitation centres should be as fully equipped as possible for the treatment they provide and have a multi-disciplinary team of staff specialising in rehabilitation. They should be able to enter into agreements with specialised

hospitals so that they can take advantage of specialised forms of care and treatment. They should also have facilities for:

- initial training or renewed training in exertion;
- vocational counselling;
- occupational therapy and, for adults, pre-vocational occupational therapy;
- psychological or psychiatric help to enable people to adapt to their limitations in order to overcome their disability;
- speech therapy, physical therapy, etc., for specific disabilities.

2.13. The general activities of rehabilitation centres should be complemented by facilities (for instance, swimming pools, halls for entertainment, film shows, plays, etc.) for organising recreational activities that allow integration with the outside world.

2.14. 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.

3. *Prostheses, orthoses and technical aids*

3.1. The medical rehabilitation programme should also include full provision for the choice, use and supply of appropriate:

- prostheses (appliances which wholly or partly replace the missing parts of the body, restoring, as far as possible, the impaired function);
- orthoses (therapeutic appliances which not only passively support particular joints but also facilitate, improve and control the functional performance of the impaired parts of the body);
- technical aids (appliances designed to compensate for those functions which, for various reasons, can no longer be performed or are performed in an abnormal way because of physical or sensory damage, including low vision aids, adapted telephones, translators, etc.).

3.2. The appliance should be supplied quickly in accordance with the medical prescription and adjusted, maintained and replaced when necessary because the provision of appropriate aids allows many children with disabilities to attend an ordinary school, assists occupational resettlement and helps towards the social integration of people with disabilities.

3.3. Fitting an appliance 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. The specialist, either alone or in consultation with the specialised institution's rehabilitation team, should – in co-operation with the person with a disability – decide on the type of appliance and the model best suited to the patient, ascertain the latter's ability to adapt to it and specify what special devices are needed in each particular case.

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

3.5. Training in the use of appliances, including regular follow-up procedures, must be available for people with disabilities.

4. *Assessment of abilities*

4.1. To obtain the best possible rehabilitation programme and a prognosis for educational, vocational and social integration, a regular assessment of abilities should be performed, and people with disabilities and their families should be enabled to explore and assess their abilities. This evaluation, to be done with the collaboration of the people with disabilities should be carried out at all stages of rehabilitation as well as when they take up employment.

4.2. The medical assessment of abilities and how they might be improved should be made 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, with the direct participation of the people with disabilities and their families.

V. Education

1. *Aims*

1.1. All people with disabilities, regardless of the nature or degree of their disability, have the right to appropriate free education adapted to meet their needs and wishes.

1.2. Education should enable people with disabilities to:

- achieve the highest possible level of personal development;
- be stimulated to learn, taking account of their disabilities and using aids to facilitate learning;
- accept their disabilities and acquire the skills necessary to overcome the obstacles they face.

1.3. Education should help people with disabilities to achieve economic independence as far as possible and contribute to their country's social development. Apart from teaching academic skills, education of young people with disabilities should include:

- social skills and preparation for an independent life in co-operation with parents and educational staff;
- practical assistance to enable them to cope with life and to integrate into society.

1.4. The objectives and the means put into operation to educate the child with a disability form part of an individual pedagogic, educational and global therapeutic project which is adapted to the child's needs, abilities and wishes. The responsible professionals should associate the child's family as much as possible and in an active way with the drawing up of this project, its implementation, its follow-up and its assessment. The family should consequently be regularly kept informed of the child's evolution and should be given as much support as it needs.

1.5. Taking into account the principle of early intervention, it is in the child's interest:

- to begin medico-educational measures at pre-school age, especially where they are intended to make it easier for the child to obtain a school education at a later stage;
- to attend school or pre-school classes from a very early age.

1.6. Contacts between children with and without disabilities provide a powerful stimulus for the integration of both. Therefore education should be provided in an ordinary environment together with their peer groups wherever possible and whenever the necessary assistance, support and fostering for young people with disabilities can be given there; to meet their specific needs, the supply to children with disabilities of special therapeutic, technical and educational aids should be ensured in every case. Whether the child's individual situation requires specialised education, mainstream education, or some combination thereof, a "continuum of provision" is essential and involves:

- close co-operation between special and mainstream schools;
- contact between children with and without disabilities of the same age;
- encouragement of transition to mainstream schools where possible and desired.

Innovative approaches to help individuals should be encouraged.

1.7. Nursery schools or, in some cases, early pedagogic guidance services, are a favourable starting point for educating children with and without disabilities together, since they are able to use flexible means of encouraging individuals; the children learn to socialise with each other, and the principle in subsequent education of standardising performance does not apply.

1.8. The nature and type of school should be chosen by means of a careful assessment process in which parents and children with disabilities are assisted by a multidisciplinary team of specialists using pupil guidance techniques and focusing on the child's particular abilities, wishes and needs.

1.9. Special attention should be given to the role and impact of new technology on teaching planning processes. Ways should be investigated in which computers can be used to support children with disabilities in education.

1.10. Since contacts between the school and the child's family are essential, the family's interest and participation in the work of the school should be encouraged. It should be noted that the child's transition from one educational environment to another calls for a great deal of adaptability on the part of both the child and his parents, who may all need psychological support.

1.11. All children with disabilities, whatever the nature of their disability, are entitled to an appropriate education in an appropriate environment according to their needs and the wishes of their family.

1.12. All people with disabilities who can benefit from it should be given the opportunity of continuing their education and training.

2. *Mainstream education*

2.1. To enable the largest possible number of children with disabilities to attend a mainstream school, the following requirements must be satisfied:

- medico-therapeutic and psychological services;
- adapted class size in which the main teacher should be assisted, if necessary, by other adequately qualified staff;
- premises and equipment suitable for children with disabilities including measures for improved accessibility and transport;
- specially adapted teaching methods and materials, curricula and examination regulations;
- counselling, implementation and action concepts which take account of the kind of disability concerned.

2.2. Because:

- trying to educate children with disabilities alongside able-bodied children without supplying the necessary support systems diminishes their chances of equality; and
- it depends on the circumstances in each case and especially on the specific disability whether children with disabilities make better progress in a special or in a mainstream school,

the wishes and aims of parents and the extent to which educational and therapeutic facilities are provided near their homes should be carefully considered.

3. *Special education*

3.1. 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, for instance a special nursery school.

3.2. Special schools and vocational training schools should be set up in sufficient number, equipped with the necessary collective and individual technical support, staffed by teachers with adequate special teaching qualifications, installed as resource centres for mainstream schools and linked with mainstream schools to increase co-operation.

3.3. Where residential care for children is essential, it should be provided in a family atmosphere. To avoid prolonged absence of the child it may be desirable to place children in foster families. Frequent contacts between the children with disabilities and their parents should be encouraged.

3.4. Special teaching should continue for as long as the person with a disability profits by it.

4. *Education and rehabilitation*

4.1. During education, pupils with disabilities should have access to programmes and resources enabling them to prepare for future employment, such as vocational guidance and other support systems.

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

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

4.4. Young people with disabilities, and especially those who have learning difficulties, should receive special educational support during their course.

4.5. Educational establishments should be easily accessible and structurally adapted to the needs of children with disabilities.

5. *Education of adults with disabilities*

5.1. Particular attention should be paid to the role of adult education, especially in so far as people with mental disabilities are concerned. Adult education should provide the maximum range of opportunities for people with disabilities, including training in basic skills and specialised education.

5.2. The particular needs of elderly people with disabilities should be taken into account, since they vary from those of other adults with disabilities. The elderly can benefit significantly from education in access, self-management, living skills, etc., as well as from participation in mainstream adult educational programmes.

VI. Vocational guidance and training

1. *Assessment of vocational aptitudes*

Persons with disabilities should have access to the assessment of their capacities which:

- are necessary to explore their possibilities of achievement;
- help identify their options regarding potential occupations;
- provide the basis for their programme of rehabilitation and integration;
- may help them to find appropriate employment or re-employment.

Vocational guidance should include an analysis of the medical, psychological, educational, occupational and social situation of people with disabilities and their probable evolution. It should be made by specialists who understand people with disabilities and what they can achieve, on the one hand, and the requirements of working life on the other, with a view to providing the most adequate prognosis, and in co-operation with these people.

2. *Guidance*

2.1. Vocational guidance should determine the occupations most suited for people with disabilities, and enable them to choose an occupation according to their knowledge and abilities. It must take into account the personal wishes of the individuals concerned and be based on the most thorough possible assessment of their occupational aptitudes.

2.2. Such guidance equally concerns people who have been in employment, those who do not yet have any experience of work or those who are temporarily unable to work. The previous occupation of the person with a disability, the special requirements of the occupation concerned and the possibilities of the labour market must be taken into consideration.

2.3. Vocational guidance should be provided as early as possible, in other words as soon as the person's situation makes it possible to envisage his entry into or return to working life. In the case of young people with disabilities, it should be provided for pupils in all types of educational environment.

2.4. People with disabilities should have easy access to mainstream employment advisory services, but special vocational guidance may be desirable because:

- equipment adapted to impairments must be available;
- the staff must be trained in special assessment techniques and know about impairments and their development.

2.5. Special vocational guidance centres or special facilities in general centres should consequently be made responsible for advising people with disabilities on suitable occupations or on training that will enable them to secure employment. These centres or facilities should be organised in the form of networks and ensure close co-ordination with the institutions and services responsible for rehabilitation.

2.6. With certain impairments requiring special treatment and medical follow-up, the special centre or service should intervene in the course of medical rehabilitation after a sufficient period of observation and, at the latest, after stabilisation of the treatment under continuous medical supervision.

2.7. The decision whether to carry out special assessments and, if so, the choice of methods, depends on a person's age, educational attainments and occupational status. In all cases strict and well-tried methods should be combined with research and innovative techniques so as to ensure that all the aptitudes and potentialities of the people concerned are taken into account.

2.8. Guidance services or centres should be provided with sufficiently qualified staff working in multidisciplinary teams. The 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, an occupational therapist or a technical instructor.

2.9. The person with a disability and, if necessary, his family or representative should have active involvement in all the guidance measures taken.

2.10. The person with a disability should not be discriminated against in terms of access to vocational guidance and training on the basis of age, sex, race, origin, religion, etc.

3. *Vocational training*

3.1 The aim of vocational training and rehabilitation should be to help people with disabilities to obtain or retain employment, to advance in their career and thereby to facilitate their integration or reintegration into society. The vocational integration programme should endeavour to set out and develop the concepts of Convention 159 and Recommendation 168 of the International Labour Organisation on vocational training and rehabilitation in order to further the integration of people with disabilities.

3.2. Vocational training and rehabilitation should:

- be open to all categories of people with disabilities;
- cover all types of activity in order to increase the range of vocational choice for the people concerned; and
- as far as possible be adapted to developments in the employment market.

3.3. Vocational rehabilitation should be initiated as soon as possible. To this end, medical and social rehabilitation services should co-operate on a regular basis with the bodies responsible for vocational rehabilitation.

3.4. Whenever the disability of the person concerned is not a major obstacle, the ordinary training system should be used. However, the ordinary system may need to be modified and should provide adequate facilities for the vast range of individual disabilities and differences.

3.5. Special vocational training and rehabilitation courses in special schools, medico-educational institutions or vocational training and rehabilitation centres may be required on account of the kind or severity of the disability or in order to guarantee the success of the rehabilitation process. Training within places of employment should be encouraged. Specialised training may be envisaged when it facilitates integration into the normal working environment.

3.6. Vocational training and rehabilitation should, if necessary, be accompanied by medical surveillance of the person with a disability, possibly in collaboration with the functional or medical rehabilitation services.

3.7. Reports should be made periodically on the development of each training or rehabilitation programme, in collaboration with the vocational guidance centre.

VII. Employment

1. *Principles*

1.1. To permit the fullest possible vocational integration of people with disabilities, whatever the origin, nature, and degree of their disability, and thereby also to promote their social integration and personal fulfilment, all individual and collective measures should be taken to enable them to work, whenever possible in an ordinary working environment, either as a salaried employee or self-employed person.

1.2. People whose professional capacity for productive work is limited and who are so severely disabled that it is impossible for them to work temporarily or permanently in an ordinary working environment should find a place in sheltered employment.

1.3. Some people with disabilities may need a modified programme combining elements of sheltered employment in a more mainstream working environment. Such supported or transitional employment should be available according to the individual's needs and wishes.

1.4. Some people with disabilities will never be able to work. Every effort should, however, be made to permit them to lead a life that provides them with satisfaction. Those with the most limited aptitudes should therefore be guided towards occupational activity centres which allow them to carry out activities without regard to productivity whilst at the same time seeking to develop their functional, social and vocational abilities.

1.5. Special attention should be paid to the role of computers and the impact of new technology on employment prospects. Ways should be investigated in which computers can be used to support people with disabilities at work and to avoid the use of new technologies causing new barriers to the employment of people with disabilities.

1.6. Close attention should be given to both the human and technical means that may be employed in order to make possible full integration into working life. Such means should include collective measures for the benefit of all people with disabilities and special measures to solve individual problems. If integration is to be achieved, the full participation of people with disabilities is essential.

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

– provided with the administrative and financial resources to resolve the general or individual problems encountered in settlement of people with disabilities in employment; and

– easily accessible to those concerned.

1.8. Employers' organisations and trade unions, as well as government departments and organisations of people with disabilities, should be informed of these arrangements and be associated with the integration effort, at regional and local level as well as at national level.

1.9. Employment of people with disabilities and measures to achieve this should always have priority over the financial assistance to people with disabilities, without prejudice to the financial support required to compensate for the extra cost of the disability. Care should be taken to maintain a balance between measures aimed at vocational integration and financial assistance to the people with disabilities, to ensure that efforts to achieve integration are not thwarted.

2. *Employment in an ordinary working environment*

2.1. In order to ensure equality of opportunity in employment for people with disabilities, measures should be taken to avoid all discrimination in obtaining and keeping a job, and in remuneration and career prospects.

2.2. The services responsible for the placement of people with disabilities should assist their employment in an ordinary working environment, as far as possible, by individual measures, such as:

– ensuring that all people with disabilities obtain the highest vocational qualification possible;

– finding the job best suited to the aptitudes and wishes of the individual, impeded as little as possible by the disability and helping to overcome its effects;

– adapting the workplace to take account of safety or operational requirements resulting from the employee's disability;

– providing special tools and special or adapted clothing needed because of the nature of the disability;

– supplementing wages during the period of adaptation to the job needed by reason of the employee's disability;

– working out a means of evaluating any reduction in output and ensuring that there is compensation for the proportionate wage reduction;

– measures to offset exceptional expenditure arising from the employee's disability;

and collective measures such as:

– support for the creation of new jobs;

– employment incentives;

– employment quotas;

– reserved employment.

2.3. Follow-up action for as long as necessary should be taken by the placement services in collaboration with other services concerned to ensure that people with disabilities placed in employment are satisfactorily resettled there.

2.4. Steps should be taken to make employers and workers aware of how they can contribute to the rehabilitation into work and employment of people with disabilities. Without prejudice to existing legal undertakings, such steps should be:

– to encourage, to the extent required by national conditions, employers and employers' organisations, autonomously or within the framework of the structures where they are represented, to create or help in creating jobs for people with disabilities, particularly through collective agreements or the establishment of quotas for employees with disabilities;

– to encourage employers generally to facilitate the integration of people with disabilities by making suitable work available to them by adapting the work itself, the assignment of tasks and posts, the timetable, tools and equipment, the workplace and other facilities, and by making the place of employment accessible;

– to give people with disabilities the opportunity to return to suitable types of employment as soon as they are medically fit for work even if they are not 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 people with disabilities, 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 people with disabilities;

– to urge employers to sub-contract suitable production to supporting workshops or to people with disabilities working at home or away from home and, if possible, to supply them with the necessary material and machinery.

2.5. Within the framework of a policy for the employment of people with disabilities in an ordinary working environment, situations and posts for people able to work in an ordinary working environment should be promoted, these being subject to the provision of specific and individualised measures to help people with disabilities and also to assist the firm willing to employ them.

These support measures should be as flexible and varied as possible in order to be adaptable in the best way to each particular case (incentive, training, preparation and attendance measures for the person with a disability and the firm).

People with disabilities seeking employment and having professional capacities, even if these are limited, but who are unable to obtain employment immediately by common law, should have priority guidance to these assisted jobs, this certainly being the best way to give access to the greatest number of workers with disabilities to genuine insertion into a profession.

As regards working conditions and life in the firm, the situation of people working in this type of job should be assimilated to a maximum degree to that of the other workers in the firm without prejudicing a more favourable salary because of the handicap.

3. *Sheltered employment*

3.1. Sheltered employment should be open to people who, because of their disability, are unable to obtain or keep a normal job, whether supported or not; it can cover a number of diversified situations, amongst which are sheltered workshops and work centres. Sheltered work should have a double purpose: to make it possible for people with disabilities to carry out a worthwhile activity and to prepare them, as far as possible, for work in normal employment. To this end, all ways of facilitating the passage from supported to ordinary employment should be devised, such as: the setting up of sheltered work sections in work centres or work centres in sheltered workshops; the setting up of sheltered work sections or work centres within ordinary firms; individual or collective detachment of workers in sheltered workshops or work centres to ordinary firms.

3.2. Workers with disabilities should be given, as far as possible, work suited to their occupational capacities. Whenever necessary, the sheltered employment workplace should have suitabie entrance and exit facilities, 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 handicap, feel cut off from other workers.

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

– the suitability of the person with a disability 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, provided by adequate supervisory staff;

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

3.4. Sheltered workshops should:

– provide people with disabilities with useful and remunerative jobs and should also provide any necessary personal assistance;

– constitute a production unit independent of normal firms;

– form part as far as possible of the competitive economic system while respecting the task of supporting the person with a disability.

– offer satisfactory remuneration in relation to the type of work performed as far as possible, comparing well with open industry, and bring the person with a disability into the social security scheme;

– endeavour to be financially viable as far as is possible considering their social purpose. This often involves a certain amount of assistance from the authorities and others, such as help with construction and subsidised running costs;

– ensure that supervisory staff have the requisite technical qualifications and, if necessary, provide additional information and training, having regard to the workshop's special role.

3.5. Workers with disabilities in sheltered workshops should have an adequate contractual status which takes into account the need for personal assistance, and establishes a normal employer/employee relationship, as far as possible. This should include the possibility of participation and adequate remuneration.

3.6. Assistance-through-work centres, where they exist, make provision for receiving people who, because of their disability, cannot work in a sheltered workshop nor in an ordinary working environment, but who are none the less able, thanks to medical and social support, to carry out a remunerative professional activity which is distinct from a purely diversionary activity.

4. *Work at home and away from home*

4.1. Work at home or in other locations could be an acceptable solution for people who are unable to leave their homes or have serious difficulty in getting to work because of:

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

4.2. Work at home or away from home may be:

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

4.3. Work at home or away from home for a firm or a sheltered workshop should be useful and sufficiently well paid and bring people with disabilities into a social security scheme.

4.4. For people with disabilities, working at home or away from home entails medical, occupational and social protection and assistance. If the person with a disability wishes to become self-employed, a scheme of financial assistance at the start should be available to him.

VIII. Social integration and environment

1. *Principles*

1.1. The various measures of the whole rehabilitation process should always aim at furthering the autonomy of people with disabilities as individuals and ensure their economic independence and full integration into society. Therefore, individual and collective measures should be included and developed in the rehabilitation programme to ensure that people with disabilities remain or become independent individuals, able to have a social life as normal and complete 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 both physical and psychological independence. The adaptation of urban structures and town planning, access to buildings and housing, transport, communication, sport installations, cultural activities, leisure pursuits and holidays are factors which should all have a bearing on the goals of rehabilitation. Wherever possible, it is advisable and important to involve people with disabilities and their organisations at all levels of policy development.

1.2. Legislation should take account of the rights of people with disabilities and contribute, as far as possible, to their participation in civil life. When people with disabilities are not able to exercise their citizens' rights fully, they should be helped to participate as far as possible in civil life, by means of appropriate assistance and measures.

1.3. The availability of information is a condition and a key to independent living. Not only professional workers should be able to pass on information on all spheres of life; it should be possible for people with disabilities themselves to obtain information. National and regional information centres can meet these needs.

1.4. Social counselling, social services, family help and guidance, and possibilities of participation by people with disabilities themselves and by organisations of and for them should be encouraged as basic conditions for attaining integration through full participation and equality of opportunity.

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

1.6. These arrangements should include, besides the most appropriate equipment for people with disabilities, the availability of technical aids enabling them to pursue their daily personal and occupational activities safely and to communicate, travel and engage in sport, cultural or leisure activities.

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

1.8. Appropriate measures should be taken to ensure for people with disabilities, including people with mental disabilities, lifestyles which allow emotional and sexual relations to develop as normally as possible. This includes information and sexual education in schools and institutions.

2. *Accessibility*

The criteria set out in the publication *Accessibility – Principles and guidelines*[1] should be taken into account in building policies.

2.1. Measures should be taken to promote public awareness and dissemination of knowledge with regard to accessibility. These measures should be focused on all the following groups involved in achieving accessibility during the building process, the planning of buildings and the man-made environment and should cover all types of disabilities (motor, sensory and mental):

– people with disabilities, both private individuals and those associated in interest groups;

– people in the service industries, teaching staff, manufacturers, etc.;

– architects, town planners and designers, those who commission work, funding and subsidising bodies, whether attached to local, provincial or state authorities or private institutions;

– policy-makers;

– maintenance, cleaning, security staff, etc.

2.2. Regulations governing the construction of dwellings, public buildings, tourist and leisure establishments, sports facilities and installations used by the public, should include basic standards for access to all these buildings and their equipment by people with disabilities, such standards being taken into account when granting subsidies, for building permits and planning permission.

Similarly, regulations should be drawn up regarding the adaptation of existing dwellings and the granting of financial help.

Regarding dwellings, particular attention should be devoted to ensuring that, besides accessibility, the living space be also adapted to an interactive use according to the need of people with disabilities.

2.3. The symbol of access devised by Rehabilitation International should be used for indicating the location of adapted facilities for people with reduced mobility. Other international symbols, covering other types of disability, should be promoted.

2.4. Basic standards for a barrier-free environment should be authorised on a national level, while international acceptance by means of authorisation by the Committee of European Standards and eventually by the International Standards Organisation should be encouraged.

2.5. Authorities should consider the needs of people with disabilities and consult their organisations when discussing urban renewal plans. Plans and projects must be assessed in terms of accessibility levels.

The development of an "accessibility chart" should be seen as a standard procedure in town planning.

1. Council of Europe Press, 1993.

2.6. The general environment should be made as accessible as possible, including such measures as establishing standards of accessibility for all shops, offices, streets, services, etc. Such provisions should take into account the variety of disabilities and their resulting needs.

2.7. Measures should also be taken to encourage research on improving accessibility. This involves the need to evaluate the degree of success of proposed solutions by monitoring their use.

3. *Transport*

Adequate transport facilities are essential in giving people with disabilities 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 the mobility of people with disabilities.

3.1. Public transport authorities should be invited:

– to recognise that everybody has a right to public transport;

– to make possible or facilitate travel for passengers with disabilities, in order to promote their economic and social integration by designing or adapting the various systems of public transport including infrastructures;

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

– to draw the attention of transport companies to all kinds of measures which could be taken to make possible or facilitate the use of public transport by people with disabilities and the importance of transport staff giving them assistance.

3.2. For individualised transport, authorities should arrange for the provision, as far as possible and according to need, of:

– wheelchairs for indoor and outdoor use for people with severe disabilities whose independence of movement is seriously restricted;

– cars, if necessary with adapted devices, for regular use on public highways, by people with disabilities if their physical and mental abilities permit them to drive; or

– light vehicles, with or without a motor, particularly suited to the condition of the person with a disability;

– adapted transport for people with visual impairment.

If necessary, financial assistance should be granted to people with disabilities who are unable to use the public transport system without assistance and for the purposes of adapting a car to their special needs.

3.3. Door-to-door transport for people with severe disabilities who are unable to use public transport should be encouraged by the relevant authorities in each member state.

The cost of special services should be met by public welfare authorities who should consult voluntary organisations as well as people with disabilities and their organisations as regards planning and running the services.

4. *Housing*

4.1. People with disabilities should be able to live independently in ordinary homes, and be integrated in society. To this end:

– all new housing accommodation should be accessible and adaptable;

– subsidies and/or tax exemption benefits should be granted to adapt existing housing;

– architects and building constructors should receive training on adaptations to houses and buildings for people with disabilities;

– proper access should be provided.

4.2. A wide variety of housing possibilities should be available, ranging from normal adapted houses, if necessary with therapeutic or social support, via semi-communal accommodation to residential care.

4.3. Besides a wide range of housing possibilities, alternative forms of family accommodation should be available for people with disabilities, such as:

– temporary respite care, in other words for sickness, holidays, weekends;

– foster families.

4.4. People with disabilities living at home, requiring support and assistance in their daily living activities or in need of more than temporary medical or other care, should be entitled to receive such help in their homes.

4.5. To this end care services should be organised in such a way that people with disabilities can obtain help in the home when needed at any time of the day or night.

4.6. Where residential care is required, measures should be taken to:

- ensure that the rights of people with disabilities (including full participation and self-determination) are protected and their wishes taken into account;
- offer psychological and social counselling to the residents and their families; and
- encourage the move towards more open and smaller units where the person with disabilities can have some degree of independence and privacy.

4.7. People with disabilities moving from institutions with intensive forms of care to other forms of housing should initially receive training in independent daily living and continuing support later.

The possibility for people with disabilities to move into normal housing should be maintained.

5. *Technical aids*

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

5.2. Agencies responsible for providing such aids should maintain a complete list and make it available to the individuals and institutions concerned.

5.3. Particular care should be taken to determine the technical characteristics, price and resistance to use of each of the technical aids available on the market in order to establish what guarantees are being offered to users with disabilities.

5.4. To ensure optimal resettlement, statutory authorities should cover, wherever possible, the cost of such appliances or equipment as well as their maintenance and renewal.

6. *Communication*

6.1. With a view to encouraging people with disabilities to participate as far as possible in society, it is desirable to make all means of communication: television, radio, press and telephone, available to them.

6.2. Among the measures needed the following examples may be mentioned:

- the subtitling and interpretation into sign language in television programmes;
- induction loops in public buildings;
- distribution of papers in Braille or large-sized print;
- adaptation of telephones for people with hearing impairment;
- telecommunication services (Minitel, for instance);
- interpretation into sign language in public places (courts, etc.).

More specifically, telephones and other means of communication should be supplied and installed at reduced cost, where individual needs or the severity of the person's disability make it essential.

6.3. The development of technology, particularly microprocessors, has produced new advanced aids and techniques which can improve communications for people with disabilities. If possible, these aids should be made available to help people with disabilities in their daily life.

6.4. The use of newly developed alarm systems make people with disabilities and the elderly feel secure at home. Such systems should therefore be made available to them.

7. *Sport*

7.1. Sport, including competitive sport, should be recognised as one of the vital factors in the rehabilitation of people with disabilities, particularly with regard to their integration into society.

7.2. Sporting activities for people with disabilities should therefore be extended 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 sporting activities.

7.3. In accordance with the objectives of integration, appropriate measures should be taken for people with disabilities to take part in sporting activities in the company of the able-bodied.

7.4. Public sports facilities, including changing rooms, lockers, showers, etc., should be accessible to and usable by people with disabilities.

7.5. All relevant public authorities and private organisations should be aware of the sporting and recreational wants and needs, including in education, of all people with disabilities.

7.6. In some cases, people with disabilities benefit more from or prefer separate specialised sporting facilities, which should be available and accessible.

7.7. Policies should be developed to give the general public more information on sport for people with disabilities. Active involvement of major sports organisations should be encouraged.

8. *Leisure time and cultural activities*

8.1. All leisure, cultural and holiday activities should be made accessible to people with disabilities. In addition, special activities should be provided for them, when requested and where the conditions permit them. Active participation of people with disabilities in all cultural, social and political activities should be promoted, including the opportunity for involvement at a professional level.

8.2. Structural, technical, physical and attitudinal obstacles which limit the enjoyment of the above activities should be removed. In particular, access to cinemas, theatres, museums, art galleries, tourist venues and holiday centres should be improved. Access to means of transport and independent mobility should be encouraged. Awareness training for staff working in leisure and cultural centres should be made widely available.

Cultural and leisure venues should be planned and equipped so that they are accessible and can be enjoyed by people with disabilities.

8.3. General guide books on leisure, tourism and culture should include all possible information on facilities available to people with disabilities, including transport, hotels, restaurants and sports facilities. They should indicate by accessibility symbols essential access facilities including toilets, facilities for people with sensory and learning difficulties, availability of assistance, etc. The symbols should follow international conventions, and the keys should be given in several languages. Such guides should be available in accessible forms, including Braille, large print and tape.

8.4. All means to improve access and enjoyment of leisure, culture and tourism for specific groups of people with disabilities should be introduced. Examples may include:

- specific guidebooks for special categories of people with disabilities, describing particular facilities for people with learning difficulties or who are visually impaired;
- encouragement of the use of audio-cassettes providing specific guides for visually impaired people;
- provision of sign interpretation for cultural and leisure activities;
- provision of audio-description in theatres and cinema for visually impaired people;
- flexible arrangements for seating to enable visually and hearing impaired people to have access to suitable places in cultural performances;
- provision of models, maps and relief plans for people with sensory and learning impairment;
- public promotion of an "accessibility chart".

8.5. Government institutions, leisure and cultural organisations should develop comprehensive access policies and action programmes designed to bring significant and lasting improvements in access for all people with disabilities.

IX. Social, economic and legal protection

1. *Scope and principles*

1.1. In order to avoid or at least to alleviate difficult situations, sidelining and discrimination, to guarantee equal opportunity for people with disabilities, and to develop personal autonomy, economic independence and social integration, they should have the right to economic and social security and to a decent living standard by:

- a minimum livelihood;
- specific allowances; and

– a system of social protection.

1.2. If there is a global system of economic and social protection for the population as a whole, people with disabilities should be able to benefit fully from it, and their specific needs must be taken into consideration. In so far as this does not exist, a specific system must be established for continuous provision for people with disabilities.

1.3. Socio-economic protection must be ensured by financial benefits and social services. This protection must be based on a precise assessment of the needs and the situation of people with disabilities which must be periodically reviewed in order to take into account any changes in personal circumstances which had been the reason for such protection.

1.4. Economic protection measures must be considered as one of the elements of the integration process for people with disabilities.

2. *Economic and social security*

2.1. In addition to social benefits granted to people with disabilities as well as to other people (for example unemployment benefits), the economic and social security system should grant:

– special benefits in cash or in kind, for people with disabilities, covering rehabilitation and other special needs, such as medical treatment, vocational training, technical aids, access to and adaptation of housing, transport and communication facilities;

– special financial support for families who have a child with a disability;

– adequate assistance, for example installation allowances or investment loans for people with disabilities wishing to become self-employed;

– a minimum livelihood covering their and their families' basic needs and requirements for people with a degree of disablement which prevents them from working;

– benefits for people who need the continuous assistance of another person because of their disablement;

– benefits to people who are unable to seek employment because of care provided to a person with a disability;

– where financial assistance is given up in order to take up employment, this financial assistance should be protected and guaranteed if employment proves unfeasible;

– benefits to people with disabilities who, on account of their disability, are able to work only part-time.

2.2. Fiscal measures should be provided to cover the particular expenses incurred by people with disabilities in everyday life, especially for the acquisition of technical aids and vehicles if not covered by the social security system.

3. *Legal protection*

The exercise of basic legal rights of people with disabilities should be protected, including being free from discrimination. In cases where people with disabilities are partially or totally unable to administer their own property, they should be provided with legal protection such as in the form of a guardian or legal assistant. This protection should not be more restrictive than necessary and should be based as fully as possible on the individual's wishes.

4. *Social services*

4.1. The varying needs of people with disabilities in respect of social counselling and social services should be covered primarily in the general framework of social services, but in order to respond to the specific needs of people with disabilities in some cases:

– specific services will have to be used; and

– the services should provide for as much activity and individual autonomy as possible.

4.2. Information, guidance and assistance should be offered to any person suffering from a disability about facilities and services available to meet their needs.

4.3. Home care services should make it easier to keep people with disabilities in their usual environment, leading an independent life, and provide a whole range of activities of a domestic and social nature, psychological support and rehabilitation for people with disabilities and for families encountering serious difficulty in providing for their daily needs. These services should include:

– assistance with housework;

– meals at home;

– child care assistance;

- company at home and aid for outside activities;
- information services such as interpreters, taped newspapers, etc.;
- telephone and tele-alarm aids to call emergency services;
- help with activities of daily living (ADL).

4.4. Promotion and co-operation services should strengthen the active life of people with disabilities in their communities and make it easier for them to take part in common tasks, and also stimulate social measures, particularly voluntary work and associations by:

- promotion and stimulation of associations and co-operatives;
- technical and financial support of organisations dealing with people with disabilities;
- awareness and promotion campaigns in collaboration with relevant bodies, associations and the media;
- encouragement of voluntary work;
- promotion of participation in various aspects of social and community life;
- leisure, artistic, cultural and sports activities.

4.5. Specialised support services should meet the specific needs of people with disabilities, including activating care, where it is not possible to apply the principle of normal integration because of the extent or complexity of disablement, by:

- ambulatory treatment; or, where this is not possible,
- a residential system;
- centres for occupational activities.

4.6. Centres for occupational activities for people with disabilities should offer opportunities for integration into the community, social contacts, and for training of personal development through constructive leisure and occupational activities:

- day centres for people with mental disabilities which provide care, psychological guidance, education, and opportunities for various activities, companionship and social integration;

- activity centres for people with physical disabilities which should cater for those who are unable to find employment or do not follow an educational course.

These institutions should have a differential and varied programme, mainly consisting of leisure and creative group activities, with emphasis on social aspects. The programme and working method should be adapted to the individual capacities of the participants and needs regular evaluation.

X. Training of persons involved in the rehabilitation process and in the social integration of people with disabilities

1. *Principles*

1.1. All those whose duties require them to take action in areas of rehabilitation and integration of people with disabilities, either directly or indirectly, should be given adequate training. This is essential for all professions concerned with the care of people with disabilities, especially in the light of their movement from institutional to community care. Such training should aim at helping people with disabilities to live as normal a life as possible. Education and support for parents are also essential to help people with disabilities to live in the community.

1.2. Training should be understood in the widest sense and should embrace:

- general training, which normally leads to a diploma and forms the basic qualification for the work concerned;
- additional professional training specific to the field or discipline in question;
- specialised training in rehabilitation.

It should emphasise the following aspects:

- introduction or adaptation to the teamwork required by rehabilitation;
- introduction to the techniques of communication and teaching methods;
- information concerning the nature of handicaps, their repercussions and the role of rehabilitation;
- the active role in the rehabilitation process played by the people who are or who are in danger of becoming disabled.

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 and the development of society's attitude towards disabilities;

– information about technical aids contributing to the rehabilitation and integration of people with disabilities.

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 people with disabilities.

1.4. The standard of staff should be constantly improved with respect 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 people with disabilities and with the procedure for setting them in motion; in particular they should be familiar with the different vocational guidance opportunities as well as the work opportunities available to people according to their abilities.

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

– the various types of staff directly involved in rehabilitation;

– the various agencies that can assist in rehabilitation and employment, such as national, regional and local authorities;

– public and private agencies, both sides of industry and voluntary organisations that have a part to play in connection with the rehabilitation and social and occupational integration of people with disabilities.

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.

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

2. *Training of health care personnel*

2.1. 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. To this end:

– in addition to in-depth knowledge in the medical field, rehabilitation should be a subject in the basic medical course;

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

Teaching should include interaction with the people who are or who are in danger of becoming disabled and 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. Medical students should also be trained in various rehabilitation problems, including psychological training for dealing with people with disabilities and their families. A sufficient number of teachers specialised in rehabilitation is indispensable for this course.

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

– specialise in or devote themselves exclusively to rehabilitation which requires specialised training and ability to co-ordinate, plan and evaluate a rehabilitation programme;

– enter a branch of social medicine (company doctors, social insurance doctors, doctors co-operating with vocational guidance services, child health surveillance doctors);

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

2.1.3. To the above end the following should be developed:

– specific training courses in multi-disciplinary 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 the 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 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. Non-medical staff involved in medical rehabilitation work

2.2.1. 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 to be kept informed of recent developments in not only 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.

2.2.2. As regards non-medical staff:

– basic training courses should cover the concept and methods of rehabilitation and lay emphasis on the importance of interdisciplinary co-operation, 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 development of a common language and a holistic approach to treatment;

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

2.2.3. Rehabilitation should be included in the basic syllabus of nurses' training courses, stress being laid on the need for active participation of the patient and his family.

2.2.4. Specific further training courses should be developed for certain categories of nurses, carers and other non-medical staff, particularly:

– those working in specialised rehabilitation institutions;

– those working outside hospitals, such as health visitors and district nurses, work nurses, school nurses; etc.

and for supervisory or teaching staff in or outside hospitals.

3. *Training of teaching and educational staff*

3.1. All those professionally responsible for teaching and education should be provided with training including a study of special educational needs. Such training should have regard in particular to the important role of communication and the new technologies. The importance of personality development of children with special emotional needs should be stressed, and specifically the traits of adaptability, creativity and empathy should be underlined.

3.2. Those specifically responsible for teaching people with disabilities should be provided with further training enabling them, firstly, to acquire a detailed knowledge of handicaps and, secondly, to master methods and techniques of assessment and assistance.

Such training might be provided, *inter alia*, by professionals already possessing sound experience in the field of specialised education. It should also stress the vital importance of co-operation with the family circle in this field.

4. *Training of vocational and guidance staff*

4.1. Basic training of trainers should be adapted, as appropriate, to:

– the individual or group receiving training, through the provision of information about the consequences, repercussions or manifestations of various handicaps;

– the characteristics of the occupation taught and its level of qualification;

– the training context: institution, company, specialised or ordinary training, etc.

4.2. The possession of the requisite theoretical and technical or vocational knowledge by trainers is guaranteed by the award of the relevant professional diploma or by the acquisition of adequate professional experience. These qualifications should be supplemented during employment by attendance at courses of further training and by contacts with the body or services responsible for co-ordinating rehabilitation measures, as well as with guidance centres or services, doctors, centre staff, other trainers, professional organisations, etc., for the purposes of identifying problems relating to the handicaps, training and employment of people with disabilities.

4.3. The basic theoretical and practical training of scholastic and vocational guidance staff should take account of the stimulating and co-ordinating role played by guidance in the rehabilitation programme, as well as the diversity of such action: assessment of aptitudes, rehabilitation prognosis, individual, vocational and social integration programmes, vocational and social rehabilitation progress reports.

4.4. Guidance counsellors should have received training to a recognised professional standard and be conversant with impairment and rehabilitation problems; their appointment should be subject to the completion of a period of practical training in their specific field.

4.5. The general and technical training of the guidance team, which includes – in addition to a guidance officer – a doctor and social worker, where appropriate, a psychologist, a physiotherapist and a technical instructor, should be supplemented during employment by team meetings for the purposes of the training and mutual information of the participants. In order to achieve this objective, exchanges of professional information and experience should be promoted between centres as well as with the two sides of industry and the rehabilitation co-ordination body.

5. *Training of vocational integration staff*

5.1. Staff responsible for placing people with disabilities in employment should undergo selection before being appointed. In addition to basic training, they should attend induction courses either before or shortly after they commence their duties, as well as further training courses on the nature of handicaps and the various types of employment suitable for people with disabilities.

5.2. Monitors, supervisors and senior instructors in supported work should, in addition to possessing vocational qualifications, receive training in teaching methods appropriate to the specific function of such institutions.

5.3. Those who have management and supervisory duties connected with the social and occupational integration of people with disabilities should receive further or in-service training, the prime purpose of which should be to ensure that the requirements of administrative, financial and staff management are consistent with the needs of people with disabilities.

6. *Training of social services staff and social and educational support staff*

6.1. All the professional workers responsible for social service and educational support, whether or not they are specialised (welfare assistants, social workers, specialised trainers, training instructors, home helps, medical-psychological assistants, those who provide practical assistance with everyday life and others) should, as far as possible, hold a qualification for their work and be able to benefit from training appropriate to the action they have to take to help people with disabilities.

6.2. Those who have sole responsibility for people with disabilities should be able to receive further training covering handicaps and practical methods and techniques.

7. *Training of staff active in the sport, leisure and holiday sectors*

7.1. Staff specialising in sport, leisure or holidays for people with disabilities should be trained in courses held at training centres or run by voluntary organisations and appropriate to the various types of handicaps.

7.2. This training should enable them to understand the origin, definition, difficulties and implications of the handicap in the context of everyday activities and, having instilled such understanding, should enable staff to set targets in terms of independence and social integration in accordance with appropriate methodology.

7.3. It must be possible for people with disabilities to have access to all training facilities which exist in these areas.

8. *Training of architects, town planners and professionals specialising in construction, public facilities and transport to deal with the problems of people with disabilities*

8.1. For the purpose of taking early action to promote a radical and coherent policy for accessibility, the concept of integrated accessibility should be at the roots of the basic training syllabus for architects, town planners and engineers.

8.2. Adequate supplementary training should be made available for professionals in these fields. Their attendance should be strongly encouraged.

8.3. Handbooks and documentation must be updated in order to serve the purpose of total integration.

XI. Information

1. *Information*

1.1. Effective information procedures, structures and institutions should be established on the national and regional levels to fulfil the need for information on all aspects of disablement, rehabilitation and integration into society.

1.2. Information programmes are necessary because of the complexity of problems which face people with disabilities and the large number of service organisations which deal with the different aspects of their problems taking into account the need for a change of attitude of all the social partners using a continuous, consequent and permanent information process.

1.3. Information should be available for the following target groups:

- people with disabilities themselves, their carers and families;
- institutions and staff involved in any field of rehabilitation and integration;
- policy-makers;
- the general public.

1.4. The scope of information should be broad and cover:

- aims and methods of integration;
- subjects relevant to the daily lives of people with disabilities;
- socio-medical aspects of impairments, disabilities and handicaps;
- organisations in the health sector and policy for people with disabilities, for example: rehabilitation, methods of treatment, education, vocational training, employment opportunities, transport facilities, accessibility, technical aids.

1.5. Information should be provided by:

- general services like social services, telephone assistance services, social advisers and law centres;
- specialised services, e.g. in rehabilitation centres, for people with a visual or hearing impairment;
- community or pressure groups for people with disabilities or organisations of people with disabilities;
- specialised information centres and publishers.

1.6. Co-ordination should be promoted of the information, documentation and publicity work done by the various public and private agencies.

1.7. International exchange of information with respect to publications, leaflets, films or other material should be encouraged.

XII. Statistics and research

1. *Statistics*

1.1. The formulation and implementation of policy on behalf of people with disabilities, and the evaluation of its effects, must be based on the most accurate possible assessment of the situations and needs of the people concerned.

For this purpose, a reliable and coherent system of statistical information should be put at the disposal of the competent authorities. The available information must also be communicated to any individual or organisation requesting it.

Special attention should be given to the standardisation of the definition of the parameters, in order to render comparable the data from different countries.

1.2. The highest possible scientific and ethical standards should be observed in both the collection and the processing of information in order to guarantee the people concerned the utmost respect for their right to privacy.

1.3. The statistical data collected and processed must be as precise as possible and should be obtained from organisations in contact with people with disabilities (social security funds, advisory boards, employment services, social services, etc.).

1.4. The data collected should cover the various aspects of the situation of people with disabilities (demographic and family data, nature and origin of the disability, type of education, employment, accommodation, types of specialist service used, nature and amount of income, etc.).

2. *Research*

2.1. It is essential to stimulate and promote basic and operational research in fields relating to impairments, disabilities and handicaps.

2.2. All aspects relating to the prevention, identification and treatment of impairments and disabilities should thus be the subject of scientific research.

2.3. Furthermore, a programme of economic, technological, sociological and psychological research should be undertaken or supported by the competent authorities in order to determine, on the one hand, the most effective means of reducing or offsetting the handicap suffered by people with disabilities, and on the other hand, the conditions which must be met in order to integrate them as fully as possible into society.

With this in mind, particular attention should be paid to the assessment of innovatory experiments in the field of integration, and in particular those relying on new technologies.

2.4. This research should be part of a coherent general policy referring to all aspects of human life and society. It should be conducted in a concerted and co-ordinated manner and contribute to exchanges of information at national and international level.