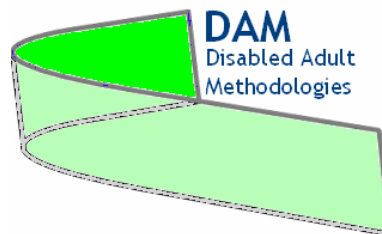




DAM

Disabled Adult Methodologies



Guidelines for education and training of persons with acquired disability

Abstract: this document deals with the proposal of guidelines about education/qualification interventions of people with acquired disability; it is intended for all the stakeholders working with them and interested in collaborating to this process; the main references are constituted by the Background Review document released in the same project and WHO ICF.

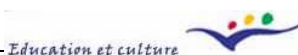
Keywords: ICF, education, training, trainee, acquired disability, resocialisation, context, evaluation, focus group.

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Introduction

Guide lines are a product of Grundtvig Project “DAM” (Disabled Adult Methodologies): they have been thought as a tool to develop appropriate education and training projects for people with acquired disability, with the aim of a reintroduction to work or to the social context .

Guide lines have been made up of the contributions of:

- Contents and theoretical references presented in *Background Document*, which is another product inside DAM Project.
- Contents derived from four focus groups, two of which have been held in Spain and the other two in Italy; focus groups have been directed to disabled people and their families and to operators who work in rehabilitation field and with acquired disability.
- Methodological approaches and experiences exchanges among all partners of DAM Project, which are:

Consorzio **TUCEP** (Perugia, Italia)

NMSC - National Multiple Sclerosis Centrum v.z.w. - (Melsbroek, Belgio)

IMSO – International Multiple Sclerosis Organisation – (Melsbroek, Belgio)

Rheinische Friederich-Whilelms- Universität Bonn (Bonn, Germania)

FELEM – Federaciòn Española para la Lucha contra Esclerosis Múltiple – (Madrid, Spagna)

COAT -Associazione “Centro Orientamento Ausili Tecnologici” Onlus – Trevi (PG), Italia

PRAGMA ENGINEERING s.r.l. (Perugia, Italia)

WMU – Wroclaw Medical University – (Wroclaw, Polonia)

To have a better comprehension of the contents of the guide lines, we invite the reader to take into account the *Background Document*, where it is possible to find a glossary of the most relevant key-words and where we introduce statistics and socio-psychological theories on acquired disability, together with services and politics for disability in the partners counties and with a view on ICF approach.

Guide lines are based, in particular, on ICF classification by OMS, for which every project should be centred on the single person’s needs and conducted by a multidisciplinary approach integrating medical, psychological and sociological aspects (bio-socio-psychological model) .

The structure of guide lines is the following:

- A general presentation of aims, target, and rehabilitation phases of guide lines use
- Acquired disability as a problem of identity recovery (resocialisation process)
- The assessment of the disabled person, of the family and of the social context as a first step to begin a training project
- The ideal curriculum of the trainers
- Training program steps and evaluation

In attachment 1 and 2 we propose ICF checklist for the description of the person, of the family and of the context and a brief health clinician information form.

In attachment 3 there is a form for the description of working capacities of the disabled person.

In attachment 4 we propose an interview for investigation of “trauma” history (trauma as an accident or the occurrence of a pathology which changes dramatically a person’s life)

The methodological approach and results of the focus group are presented in attachment 5.



1. Aims of the guidelines

The guide lines have been written with the following general aims:

- to share common languages and concepts
- to share the “reintroduction to work of disabled people” as a European value
- to develop a social and political common culture on acquired disability problem, producing positive behaviours towards it
- to sensitize social, educational and employment environment to break down barriers
- to facilitate people with acquired disability to be introduced/reintroduced to social, occupational and work contexts
- to make real the application of laws for disabled people
- to reinforce capacities of trainers to work in different social conditions and with different situations of disability
- to suggest a methodology to be applied since the early phase of a traumatic event or of a pathology manifestation
- to make real a multi-disciplinary approach, developing networks among different professional figures, organizations and services
- to make an experimentation of new practices and an exportation of them

The guidelines are also a starting point for new partnerships, to explore deeply occupational therapy and vocational therapy and to build educational projects.



2. Target of guide lines (users)

These guidelines are mainly addressed to “trainers”: with this word from here to the end of document we refer to “case managers” of an educational and training project for persons with acquired disability.

Acquired disability always implies complex situations, so that every social-reintegration attempt has to be realised by an integrated working-group. As explained in the background review (ref. chapters on sociological background theories and on ICF), a biopsychosociological approach (as in ICF model) expects a multidimensional and multi-professional intervention, where a working-group represents:

- A) an active agent of analysis, assessment and evaluation of the global situation
- B) a stable reference for the person, because the professional figures of this working group share a project which fits with and is centred on the person
- C) a concrete and operational resource, which makes real the realization of the project.

In this approach it is recommended a central professional figure, who is called “trainer” and who directs the phases of the educational/training program and coordinates all the figures involved in it.

The trainer could be every professional involved in the pathway to social reintegration of people with acquired disability:

- Vocational trainers
- Occupational trainers
- Speech therapists
- Social Workers
- Psychologist
- Physiotherapist

We started from trainers needs and also from disabled people needs analysing them also by focus group that where performed in Spain and in Italy, the texts of which are proposed in the Annex of the present document.



3. When can guide lines be used?

All the interventions have to be directed to recollect gaps between present life and past life, with the aim of giving back the person a significant social role. Every action has to be thought very early, since the rising phase of disease or of disability.

The interventions have to be developed:

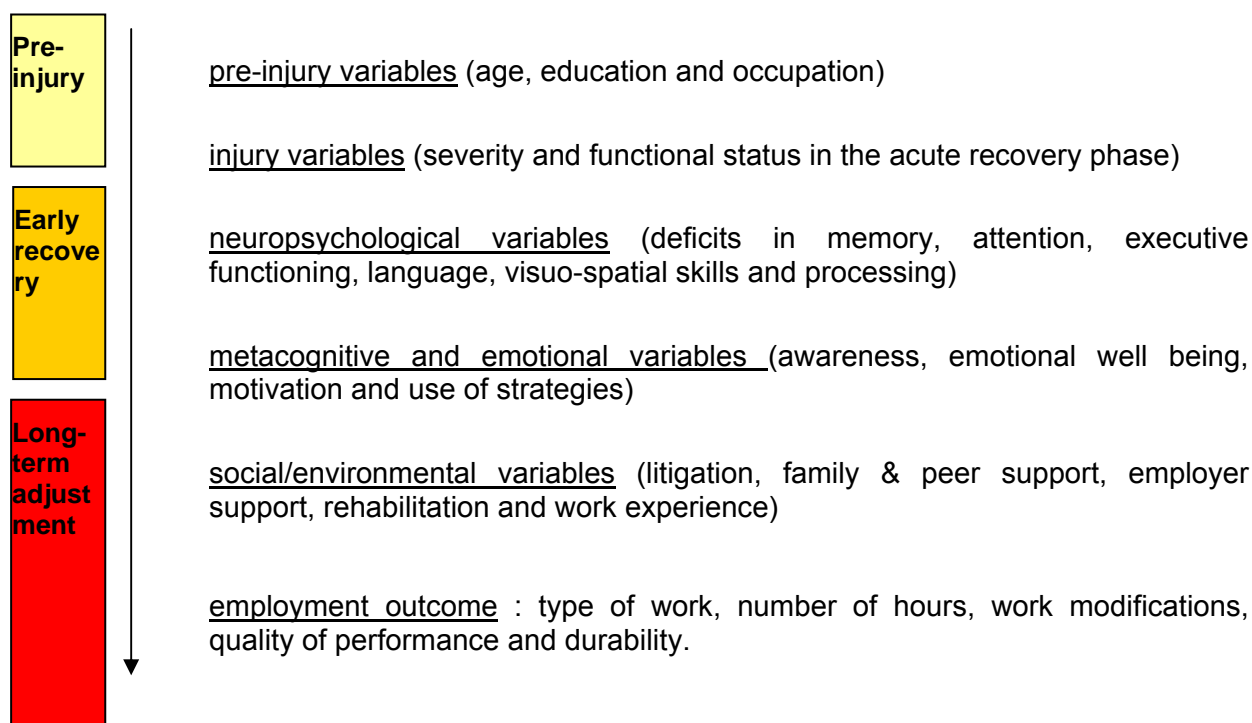
- 1) in the hospital, with an early activation of territorial services
- 2) in the life context of the person
- 3) in the social and territorial context, finding aids and providing facilities which make the context help the person.

As we explained in background document (see chapter on literature overview on vocational rehabilitation), the assumption is that an intervention has to take into account many variables from pre-injury phase to foresee an employment outcome.

Early intervention, in the case of a person with MS, must start just when the person is beginning to experience the first disabilities. This includes cognitive problems that may appear before physical problems.

A person with MS usually ends up leaving his/her job, but there are other kind of jobs or other activities that they can still do for a number of years, and that should be the aim of the early intervention: to maintain the person at work or active as long as possible.

This means to re-educate their profile somehow, and to develop new skills and abilities.



(from T. Ownsworth & K. McKenna).



All of these variables need, to be controlled, of an early care of the person since the accident (or injury, or disease) occurs.

For “complete social reintegration” we refer to an ideal outcome where the person has a personal satisfying quality of life, not in isolation and in which he is introduced to an occupational activity, not necessary in a job, but in a social context where he can perform tasks in positive relationships.

A complete social reintegration means that the person is integrated in every aspect of life. That is, at home with the family, at work (new job or same job), social life, etc.

At home the person carry out daily tasks by him/herself as much as possible and as long as possible, sometimes with technical aids and some family help.

At work, there are many adaptations that can be done to the workplace and in some countries; there are public grants to help companies making their facilities accessible for disabled workers.

Regarding social life, there are many impediments that the person with MS will come across, like architectural barriers, fatigue, transports, incontinence... but these can be solved or minimised in some ways so the person may lead a social life as normal as possible.



4. One important basic assumption: the person's recovery of identity

Acquired disability determines fear and uncertainty, instability and difficulties in planning the future.

The disabled person adaptability to acquired disability affects his motivation and his will to exit from a severe situation. This element seems to be essential for a successful reintroduction-to-work project.

Acquired disability is a traumatic event, which could get one person and his family into a complex drama.

This traumatic event could give rise to a depressive state and a disadaptive disease: it could affect the social role of the person – because of lost of working ability, lost of social status, changing of aesthetic features and of physical performances, changing of social context-modifying the personal identity based on the social context of life.

A disabled person could suffer an affront to his/her pride. Frequently occurs a "cut" with past life and past habits; even past friends tend to "disappear". The isolation enhances the personal problems and difficulties. An example in real life: a person started working in a company, but needed somebody who helped him every time he went to the toilette. Nobody wanted to do it.

The disabled person could be inclined to live apart, because of a lack of motivational stimulus.

In some cases, if pensions are higher than the salaries offered to them, they don't want to work. There should be some kind of compatibility between pensions and wages so that people are motivated to work. Sometimes disabled people ask for courses just to stay active, amused etc, not to find a job.

If the person is not still able to keep his own social role, he will change his own Self image, feeling a sense of inferiority.

"When the accident happened, in a second I was another person.

I should have met myself, have Known myself differently"

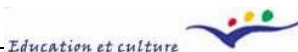
(M. Gillebert, 1992)

The "crisis of presence" (De Martino, 1973), which is the difficulty of finding a continuum with past life, should be the start point of the project of disabled person's identity reconstruction.

Presence, identity and space have to be recovered again on a biological, behavioural and relational level by the achievement of autonomy and independence.

"All of them who cruelty have been shot by life events, have to close their door on the past without regrets, but, thanks to their interior strength reached by their experiences, they will live completely with the others their new birth" (Gillebert, 1992). This process necessary needs a support: the trainers have to help and sustain this experience of personality rebuilding.

Personal Identity is the sense of being through time as a separated entity" (Galimberti, 1992): each one discover the identity in critical moments of life, when a question rises up: Who am I, now?



The construction of personal identity is the exit of some processes of individuation, which are related to the link between mind, body and consciousness.

The organization of personal identity is a never ending process. It corresponds to an organization of information about the Self, a development of self awareness. There are different levels of self¹:

- *Body and corporeity perception*, according to Stern (1985) linked to:
 - The sensation of being the author of actions (*Self working*)
 - The feeling of cohesion
 - The emotions (*emotional Self*)
 - The feeling of a continuum with the past (*Historical Self*)
- *Social and interpersonal Self*: each individual life is linked to the social and interpersonal context. We are the mirror of the relations we establish with the others.
- *Conceptual Self*: the way a person thinks her/him-self (Rogers, 1942)

We can assume that every Self recovery has to pass through each of this level: a distorted perception of body or a cut with past life, or a sense of disintegration and a lack of cohesion will affect Self image and will represent odds to the recovery of identity.

Erikson (1959) defined the development of identity as “Synthesis of the Ego” or an “unconscious effort to give continuity to personality, the maintenance of an interior solidarity with the ideals and the identity of one’s own reference social group.

Erikson suggests eight steps for the construction of identity, which we illustrate here: the personal identity construction passes through psycho-social crisis and conflicts linked to personal transformations of the subjective experience over time.

The experience of inhibition in the fifth step corresponds to an arrest of identity development, which could exit in desperation.

Psycho-social conflicts	Basic energies
Confidence <i>versus</i> Unconfidence	Hope
Autonomy <i>versus</i> shame and doubt	Will
Initiative <i>versus</i> sense of fault	Intentionality
Efficacy <i>versus</i> inferiority sense	Sense of Competence
Sense of Identity <i>versus</i> dependence	Faithfulness
Sense of intimacy <i>versus</i> isolation	Love
Creativity <i>versus</i> inhibition	Confidence
Integrity <i>versus</i> desperation	Wisdom

(Derived from Fedeli, 1990)

Goleman (1998) describes an important factor of personality, the “emotional competence” which is an ability based on emotional intelligence. Training on emotional competence corresponds to train identity recovery.

¹ For more details on Self see: Del Miglio Carlamaria; 1989; Rogers Carl, 1942; Neisser Ulrich, 1967; Kohut, 1971, 1980



The structure of “emotional competence” is illustrated in the following scheme:

Emotional competence structure	
Self awareness	<p>It is the recognition of one’s own emotions, resources, intuitions:</p> <ul style="list-style-type: none"> - Recognition of emotions and of their effects - Self analysis of personal limits and strengths - Trust in one’s own possibilities and capacities
Self control	<p>It is the ability of controlling interior condition, resources and drives:</p> <ul style="list-style-type: none"> - Self control of emotions and disruptive drives - Sense of responsibility - Adaptability - To be opened to new ideas, stimuli, information
Motivation	<p>It is based on emotional states which drive the achievement of goals</p> <ul style="list-style-type: none"> - Self realization impulse - Intentionality and effort - Optimism
Empathy (see also Stein, 1992)	<p>It is linked to the sensibility to others needs, feelings, interests</p> <ul style="list-style-type: none"> - Comprehension of other’s emotions - Promotion of others growth - To be able to understand the power balances in a group
Social abilities	<p>It is linked to the ability of keeping out desirable responses from others</p> <ul style="list-style-type: none"> - To be persuasive - To be clear in communication - To be leader - To be protagonist of changes - To build relations - To build cooperation - To work in teal or in group

(from Goleman, 1998)

First of all,

⇒ it is important to rescue the person’s self-esteem and identity. It is necessary to work on psychological aspects to locate the person in a new condition, to make possible accepting limits to avoid later frustrations, to develop emotional competence .



5. Assessment of the disabled person, of the family, of the social context

It is not appropriate comparing different levels of disability: each situation has its own specific needs and it is difficult to match a severe disability with a lighter one; it is not appropriate comparing different typologies of disability.

For this reason it is recommended to develop “*ad personam*” programs (far from generic and heterogeneous programs): an educational program aimed to reintroduction to work shouldn’t be a pre-packed educational program; it rather could be more useful to develop an “*ad personam*” educational program, taking into account some important factors which are related to the singular person and situation.

To understand who was the person before the trauma/accident and to recollect who is he now it is important to assess many aspects. First of all:

⇒ To develop an educational program aimed to reintroduction to work it is useful to start with the reconstruction of the trauma event according to the **disabled person, his/her family** and his/her **social context** perspective.

The following table shows some dimensions to be known about the person, the family and the social context referred to the past, the event (i.e. an accident or a disease), the present time, the future (Toni, 1998).

	The Past	The Event	The Present	The Future
The Disabled Person	The way he /she was	What has happened	What has changed inside and around the person	Desires, plans, expectations and opportunities
The Family	The way the family was	What has happened	What has changed inside and around the family	Family’s desires, plans, expectations and opportunities
Life and social context of disabled person	The way the context was	What has happened	What has changed inside and around the context	Context requests, offers, What expectations and opportunities

(from Toni, 1998)



To analyse the four dimensions (the past, the event, the present and the future) related to the essential world of the person, it could be used the methodology of "life stories". This approach contemplates long interviews.

Recording them could give the possibility of a deeper analysis.

The interviews can contemplate two steps:

- a preliminary group interview to the person and to his family, to piece together the past and the event

- an individual interview, centred in particular on the two consequent moments of life (the present and the future) to deal with more confidential themes and to catch every element useful for a new project of life.

The two phases of interviews can be interpreted in a second moment, using also the recordings (Toni, 1998)

To analyse all of these dimensions, here we propose an interview scheme.

The disabled person

The past:

What kind of person I was? What has changed outside and inside me?

The event:

Why (the pathology, the accident...) has happened to me?

The present:

How do I feel my body?

Who am I now?

Have I adapted myself to a new life? How it could be possible?

What could I do now?

What are my resources?

Do I have old friends? Do I have new friends?

Do I have hobbies?

The future:

What will I do/be?

What are my expectations, motivations, needs, projects?



The familiar context

The past:

What kind of family we were? What has changed outside and inside us?

What expectations? What social and economic condition?

The event:

What has happened? How the event has changed the family balance (power relations, conflicts)

What difficulties?

The present:

How do we feel (regrets, sense of fault, emotions and thoughts)?

Who are we now?

Have we adapted ourselves to a new life? How it could be possible?

What are our resources?

What could we do now?

The future:

What will we do/be?

What are our expectations, motivations, needs, projects?

The social context

The past:

How was the social context before the event? What has changed?

The event:

What has happened? How the event has changed the social context (friends, relatives...)?

What difficulties?

The present:

How do the social context perceive the disabled person (attitudes, stigma...)?

What is the social context composed of now? (friends, relatives, services, laws...)

Have we adapted ourselves to a new life? How it could be possible?

What are the resources?

What could the social context offer now?

The future:

What are the social context expectations, motivations, needs, projects?



Here we suggest some other dimensions to make a deeper assessment of the disabled person, of the family and of the social context

The assessment of the disabled person

In a framework which conceives the person as a global concept, the most important effort should be oriented to a careful and deep evaluation of the person's psychological and social status: this analysis could give the elements in order to develop a project having the purpose to reduce the isolation status.

⇒ Assess in which phase of adaptation the person is living now

According to Antonak and Livneh, we can distinguish a psychological path of adaptation to disability, which is articulated in some reaction phases:

- *Shock* is perceived as the person's initial reaction to the onset of a sudden and severe impairment (e.g. spinal cord injury, myocardial infarction) or psychological trauma (e.g. diagnosis of a chronic disease). It is a reaction noted by a psychic numbness resulting from the impact of an overwhelming traumatic experience
- *Anxiety* is viewed as a phase of panic-stricken reaction upon initial recognition of the magnitude of the traumatic event. This reaction should not be confused with anxiety as a trait-like character concept
- *Denial*, considered more problematic reaction to verify due to its subtle and often conflicting aspects, is seen as a defence mobilization against painful realization of implication of one's condition, including the expectancy of recovery from the impairment
- *Depression*, a reaction often observed among adventitiously-impaired persons, is typically conceived to reflect the initial realization of the loss of one's prior physical prowess stemming from sustained bodily insult. It is generally equated with reactive response of bereavement for the lost body part or function
- *Internalized anger* is viewed as the exhibition of self-directed bitterness and resentment often associated with feelings of guilt and self-blame. This reaction should be most evident in persons who realize their impairment is a chronic condition
- *Externalized hostility* toward people, objects or other aspects of the environment occurs when the person with impairment appears to be retaliating against his or her imposed functional limitations. It could be particularly evident with increasing chronic state
- *Acknowledgement* is made up of the cognitive recognition (i.e. intellectual acceptance) of the future implications stemming from the impairment and the gradual integration of the functional limitations associated with one's condition into one's self concept
- *Adjustment* reflects an affective internalization (i.e. emotional acceptance) of the functional implications of impairment into one's self concept coupled with behavioural adaptation and social reintegration into the newly perceived life situation.

Each of this stage of adaptation is very important: internalised anger, for example, becomes an inner resource only if it evolves towards externalised hostility and then towards acknowledgement.

It is not useful, for example, to consider negatively a depression state, because it is important to take into account the possible evolution of this state and to help the person managing every inner changing.



Now we introduce you to the dimensions you have to investigate when dealing with a training program for disabled people.²

⇒ Assess knowledge, attitudes and possible professional effectiveness

Knowledge

For Knowledge it is important to assess:

- Past experiences
- Curriculum
- New knowledge to enter the occupational activity
- Basic knowledge on computers is necessary, as in general society.
- Learning other languages.
- Organizational competences (as, for example, the mission of a company, roles, duties, procedures and protocols)

Attitudes

Among attitudes it is important to assess:

- Expectations about the future
- Subjective factors which have a strong influence on motivation and on the consequent success of the project
- Interests (in the past, in the present, for the future)
- Behavioural styles
- Capacity to accept suggestions and help.
- The level of compliance to the program
- Relational and emotional skills...

Bandura (1986) describes self cognitive control, another fundamental attitude, composed by:

- *Self monitoring*, which is the capacity of recognising the personal role and objectives
- *Self evaluation*, which is the ability of recognising the responsible agents of events in an appropriate way
- *Self efficacy*, which consists in having realistic expectations about the personal success probability in a complex duty
- *Self reinforcement*, which is the capacity of self rewarding after having reached a scope

² This paragraph is written on the basis of some literature references and on the results of interviews made with disabled people, with people who represent disabled associations and people who work with disabled people. In particular, many considerations are drawn by the results of four focus group, two of which have been realised in Spain, and the other two in Italy during DAM Project implementation.



Professional Effectiveness

It is useful to evaluate:

- The ability of the person to exploit technical advices
- Personal Skills and context skills matching
- Life skills
 - Actual capacities
 - Past experiences

The assessment of the family

For the family context it is important to assess:

Knowledge

- The degree of awareness of the family about the real capacities and difficulties of the disabled person
- the family's psychological image of the disabled person
- The cultural level and interests of the family

Attitudes

- Familiar balance and inner psychological dynamics
- the level of adaptation, emotional state , fears...
- the level of compliance of the family to the program;
- family degree of care and assistance
- Expectations
- Needs

The assessment of social context

It is important to make an analysis of social context, by considering three main factors:

- Public frame
- Employers frame
- Occupational frame
- Neighbourhood frame

Public frame

- Information opportunities
- Training and rehabilitation opportunities
- Urban organization (structures, barriers, transportation, help networks, volunteers associations...)



- Typology and quality of services
- International directories about disability
- Data availability (epidemiology, statistics...)
- Expectations (public opinion)
- Cultural stigma and barriers
- Cultural pattern
- Governance
- Development of social status
- Services working in network
- Social and political directories and programs
- Educational programs
- Availability of services
- Occupational opportunities

Employers frame

- Employer's degree of knowledge about disability.
- Employers strategies and directories
- Employers attitudes toward disability
- Employers actions and behaviours toward disability

Occupational frame

In analysing the chances to apply the person to a new job/occupation the detailed analysis of the interactions between his capacities and operation requirements could be useful. *Task analysis* is an observation-based technique that develops knowledge from the analysis of the components of a complex task. It is based on the identification of the elementary task sequence, providing the description of the requirements for the correct execution of each of them. There are several techniques to represent the analysis: list based, flow-chart based, lattice based... For each elementary action/task the abilities expressed by the person should be compared, recognising critical points and potential deadlocks.

In general, applying task analysis is a time-consuming process: often it is applied with the help of experts and supported by software tools.

⇒ Hint: apply this kind of analysis only for tasks which are identified as really critical.

Neighbourhood frame

The social context is also represented by stakeholders who turn around the disabled person. It is important to keep some information on:

- The presence of a sustaining network of neighbours around the disabled person
- The degree of neighbours awareness about the person's difficulties and possibilities
- The level of potential help by neighbourhood



Assessment tools for the person, for the family and for the social context

1. To describe the person, we suggest referring to ICF-International Classification³ of Functioning check list by World Health Organization. It is a clinician form where every aspect of the person is described for a deep assessment (Attachment 1).
2. To have a more detailed knowledge of health situation it is here presented a “brief health information” questionnaire and a form for “General questions for “General Questions for Activity and Participation” by ICF- WHO (Attachment 2)
3. To describe the potential capacities of the person at work, we illustrate a form drawn from ICF and experimented by an organism of Italian Welfare and Work Minister called “Italia Lavoro” on Public Employment Services, specifically applied for disables. (Attachment 3).

³ For more information, read the background document on ICF



6. The trainer- An ideal Curriculum

Here we discuss all the main requirements connected to a training program aimed to occupational reintroduction of disabled people in particular here we propose to analyse features that should be developed by trainers in the three dimensions of “Knowledge, Attitudes and Professional Effectiveness” referred to trainers.

	Knowledge	Attitudes	Professional effectiveness
Trainers	Lifelong learning Past experiences Curriculum Ad hoc training...	Expectations Motivation Behavioural styles Relational and emotional skills Empathy Leadership...	Educational needs and skills assessment; Ad hoc educational programs...

Now we concentrate on trainers knowledge, attitudes and professional effectiveness.

Trainers Knowledge

Psychological and medical knowledge	<p>Knowledge on the illness or situation of the disabled person to be able to carry out an appropriate approach of the training. Therefore they should also know how to treat them. This also applies for voluntary trainers.</p> <ul style="list-style-type: none"> - Psychological and pedagogic abilities, the knowledge of psychological aspects linked to acquired disability related to a new self image and corporeity of the disabled person. - Competence to deal with medical problem (i.e. decubitus ulcers; catheterization, feeding...), the competence on medical aids and helps
Occupational and training opportunities knowledge	<p>Objectives of the project in which they will work</p> <p>Knowledge of the labour market, new markets, new technologies, employment offer</p> <p>Courses that really provide possibilities of finding a job</p> <p>Vocational rehabilitation contents and methodological approaches</p>



	Competence on evaluating and monitoring training interventions Keep abreast of new changes and developments of the services
Laws and normative framework	Competence on law situation and take abreast of new laws

Trainers Attitudes

Relational attitudes	<p>Empathy, patience, no social prejudices</p> <p>Strong personality</p> <p>Communication ability</p> <p>Listening capacity</p> <p>Relational competence</p> <p>The ability to manage a sustaining relationship over the time</p> <p>The ability to work in group, in team</p> <p>To be tolerant of the disabled person's rhythms (to work out his bereavement, his depression...)</p> <p>The competence to assist the person in the emotional and cognitive match between past and present</p> <p>Awareness of the personal role and of other professional figures role</p> <p>To manage stress, distress and burnout</p>
Cognitive attitudes	<p>Problem solving, decision making abilities</p> <p>To be aware of the network around him and of the rules of each stakeholder in the network</p> <p>To be aware of their objectives and aims, of their role, possibilities and limits</p> <p>To have a lot of interest for the collective</p> <p>To analyse problems and to understand the links between biological and social level</p> <p>To be able to design, program and evaluate their actions considering the network conditions</p>

Trainers Professional Effectiveness

There is almost no special training programs aimed to job re-introduction for disabled people trainers given by public administration. They have to learn from day to day practice and experience.



Training Professional Effectiveness should be described as a combination of factors:

<p>Professional effectiveness towards the disabled person and the family</p>	<p>To start with interests and motivation of the disabled person, not only considering the perspective of his residual resources</p> <p>To avoid a relationship based on power and dependence</p> <p>To be creative to find a way to establish a confident relationship with the disabled person</p> <p>To be realistic and if there is not progress not to be depressed: the trainers have to accept that not everybody will improve as much as desired.</p> <p>To adapt training to the person's needs and abilities</p> <p>To know how to balance distance and nearness To assist a global reintroduction (on a psychological, emotional and social level)</p> <p>To make an orientation action</p> <p>To mediate with the social and familiar context of the disabled person</p> <p>To use consistent methods and different training tools</p> <p>To work with the disabled person, spending a long time with him/her, in order to find out his/her attitudes and potential capabilities</p>
<p>Professional Effectiveness towards the occupational environment</p>	<p>Assist employers in a educational-occupational program for disabled people</p> <p>To adapt the environment (house organization, architectural barriers...)</p> <p>To evaluate working opportunities to develop a specific training program</p> <p>To assume the role of tutoring</p>
<p>Professional Effectiveness towards a professional network</p>	<p>Knowledge about other services work, how to contact them, what paths to access to them</p> <p>To participate to supervision meetings</p> <p>Work in a network or in a group in contact with or entering the enterprises (or other occupational environment)</p>



7. Training program steps

How to help people with acquired disability to recover their identity and to build new competencies?

It is useful to organize a multidisciplinary network who cares of the disabled person and of his/her family since traumatic event or disease occurs. This network should assist them with a project in order to help them to face with disability and to adapt to many changes. So, trainers don't work alone, because:

⇒ The training program should be the result of a multidisciplinary team project.

The team should be composed by:

Neuropsychologist	Psychologist
Physiotherapist	Speech Therapist
Vocational Therapist	Social Worker

It should be useful to develop links and protocols between educational programs and occupational environment, making up working groups which could involve social workers, educationists, employers and other professional figures that could give an help in the educational-occupational program. To do so, it is necessary to have some basic social requirements that we discuss here.

A correct concept of rehabilitation and of training should be intended as a project of life, using every resource is present or potential in and around the person, so to establish for him a new social role and new relationships with the world.

It is useful to investigate and define a methodology of a "network intervention", taking into account a global concept of the person, of his needs and of his context (as we find in some literature - Cottini, 1997)

On the basis of the resources and the community living skills the person presents in the assessment, it is possible

⇒ to delineate objectives and aims of training/educational program

It is possible to decide which abilities could be focused and where address the program.

There are two important variables (also according ICF classification): capacities and performance.



It is important, for someone, to reach abilities which are not yet possessed, while, for others, to recover or to enhance capacities already possessed.

In the implementation phase of training intervention, it is useful

- ⇒ to think about two important aspects :
- activities and contents to propose in a sheltered or community context
- Educational/training strategies (techniques)

It is also necessary

- ⇒ to make evaluation of the training process and to help the person develop self evaluation capacity

To have knowledge of the person's possibilities, it is important for him to face with a specific performance in a specific environment: if the aim of the project is an occupational reintegration, the disabled person has to experiment himself in that occupational activity and in its specific environment, so to analyse his functioning and to adapt the environment (for example, providing it with technical aids so to overcome physical barriers).



Goleman (1998) develops a training program in the following steps:

“- **To evaluate occupation or job:** the training should concentrate on most important competencies to be able to do a specific work or to recover a specific role (task analysis).

Advice: A training aimed to irrelevant competencies is not recommendable.

Best practice: To project training on the basis of a systematic evaluation of person's needs

- **To assess the person:** the individual profile of abilities and limitations should be done so to understand the abilities to improve.

Advice: It is not useful to train people on abilities they already have improved

Best practice: to adapt training to the individual needs

- **To present the evaluations:** it is important to give a feedback about abilities and limits. This has a strong emotional importance, but it is needed professionalism in the way communicating those contents.

Advice: a feedback presented in an inappropriate way can disturb the person; differently it can be a motivating stimulus.

Best practice: To use emotional intelligence to present the evaluation.

- **To judge exactly the preparation of the person**

Advice: When people are not ready, the training is not recommendable

Best practice: To evaluate how much the person is prepared and to consider preparation, if needed, as the first goal

- **To motivate:** Learning is strongly linked to motivation.

Advice: If people are not motivated, the training will not be effective

Best practice: To make clear the probable results and consequences of the training

- **To make self monitored changes:** when the person drives the learning program to his needs, it will be much more effective

Advice: Training programs which work for everybody, actually work for nobody

Best practice: To make the person chose his goals and project the plan to reach them

- **To concentrate on clear and reachable goals:** The person needs clear information about the competence he has to reach.

Advice: programs centred on unclear goals fail and rise up confusion

Best practice: to explain specific competencies and offer practical conditions to reach them



- **To avoid difficulties and backward steps:** habits tend to change slowly
Advice: slow changes over time could affect negatively motivation
Best practice: Help people to learn by errors and experience

- **To offer feedback on performance:** a feedback tend to drive changes and helps motivation
Advice: a confused feedback can provoke distortions on training
Best practice: To organize moments of feedback, supervision, analysis of the training process

- **To sustain exercise:** a lasting change wants a prolonged exercise
Advice : a course or a seminar are a starting point, but they aren't enough. It is important to take into account life-long learning theories
Best practice: to use every occasion to make exercise

- **To organize sustain intervention:** it could be useful to make homogeneous help groups
Advice: The loneliness and solitude can be a barrier
Best practice: To build a sustaining network

- **To make available models:** some efficient persons can be a model to inspire changing in the other's behaviours
Advice: if a trainer is not coherent in the behaviour, it is not reliable
Best practice: To encourage trainer to show their competence and to be coherent

- **To stimulate:** the changing will be helped by a stimulating environment which will offer a safe atmosphere
Advice: When training is not supported by a real encouragement, every effort will be without goals or perceived as too much full of risk
Best practice: to show the importance of the requested competence to reach goals

- **To reinforce the change of behaviours:** rewards are important for everyone
Advice: Lack of rewards is not motivating
Best practice: To make sure that environment rewards every changing of the person

- **To evaluate :** it is important to define methods and criteria to understand the development of the process
Advice: no evaluation is not useful to understand errors and to prevent them
Best practice: to develop an evaluation system to assess the competence at the starting point and all the process long."



8. Training program evaluation

There should be an assessment team to evaluate the program.

First of all:

⇒ evaluate sustainability of the program in social (and also economic) terms

Then it is possible to:

⇒ evaluate the efficacy of the program

Social context evaluation⁴

Here we suggest some possible indicators of social sustainability evaluation

Social context Knowledge Indicators

There are some important aspects of knowledge that could facilitate the occupational reintroduction of disabled people

- Consistent data bases of people with acquired disability
- Interrelated networks that share information, organize meeting, match methodologies and approaches to the problem
- Information about accessibility to services
- Protocols that state procedural patterns, links, responsibilities of different services

Social context Attitudes Indicators

- The capacity to reduce prejudice and stigma on disability
- The capacity to reduce disparities
- The culture of empowering disabled resources rather than rising up their residual capacities
- The employers attitude to receive disabled persons and to sustain the project of occupational reintroduction

Social context behaviours indicators

- Care and assistance by friends or social network (and the disabled person's will to trust in and to rely on external help)

⁴ These indicators are drawn from focus groups made in Italy and in Spain during the Project.



- Presence and interaction of an integrated network of services aimed to disabled reintroduction to work
- Presence of occupational opportunities
- Presence of clear and accessible paths for reintroduction-to-work
- Training of the employers to awaken them on disability problems of reintroduction to work
- Sensibility of public opinion on disability problems and needs
- Presence of inter-institutional initiatives to empower links and dialogue among institutions
- reduction of bureaucracy and complex organization of the services in order to facilitate accessibility to occupational reintroduction programs
- Stages and presence of tutors
- Architectural barriers demolition
- Rewards to companies observing the laws. There should be a seal and a certification to the excellence in the disabled people integration.
- Presence of supervision to assist operators, employers all the process long.



Program Efficacy Evaluation

We suggest the use of a tool such as the following :

Evaluation grid of the training process and outcomes

Check of the Project	
Name	
General considerations	
Goals already reached	
Unreached goals	
New objectives	
Training program	
Check plan	



9. Attachments

Attachment 1

ICF CHECKLIST

Clinician Form for International Classification of Functioning, Disability and Health

This is a checklist of major categories of the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization. The ICF Checklist is a practical tool to elicit and record information on the functioning and disability of an individual. This information can be summarized for case records (for example, in clinical practice or social work). The checklist should be used along with the ICF or ICF Pocket version.

H 1. When completing this checklist, use all information available. Please check those used:

[1] written records [2] primary respondent [3] other informants [4] direct observation

If medical and diagnostic information is not available it is suggested to complete appendix 1: Brief Health Information (p 9-10) which can be completed by the respondent.

H 2. Date ___ / ___ / ___ **H 3. Case ID** ___st / ___nd / ___ **H 4. Participant No.** ___ , ___ , ___
Day Month Year CE or CS Case No. 1st or 2nd Evalu FTC Site Participant

A. DEMOGRAPHIC INFORMATION

A.1 NAME (optional) First _____ FAMILY _____

A.2 SEX (1) [] Female (2) [] Male

A.3 DATE OF BIRTH ___ / ___ / ___ (date/month/year)

A.4 ADDRESS (optional)

A.5 YEARS OF FORMAL EDUCATION __

A.6 CURRENT MARITAL STATUS: (Check only one that is most applicable)

- (1) Never married [] (4) Divorced []
- (2) Currently Married [] (5) Widowed []
- (3) Separated [] (6) Cohabiting []

A.7 CURRENT OCCUPATION (Select the single best option)

- (1) Paid employment [] (6) Retired []
- (2) Self-employed [] (7) Unemployed (health reason) []
- (3) Non-paid work, such as volunteer/charity [] (8) Unemployed (other reason) []



- (4) Student [] (9) Other []
(5) Keeping house/House-maker [] (please specify) _____

A.8 MEDICAL DIAGNOSIS of existing Main Health Conditions, if possible give ICD Codes.

- 1 No Medical Condition exists
2 ICD code: __. __. __. __. __
3 ICD code: __. __. __. __. __
4 ICD code: __. __. __. __. __
5 A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known

PART 1a: IMPAIRMENTS of BODY FUNCTIONS

Body functions are the physiological functions of body systems (including psychological functions).
Impairments are problems in body function as a significant deviation or loss.

First Qualifier: Extent of impairments **0 No impairment** means the person has no problem **1 Mild impairment** means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days. **2 Moderate impairment** means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days. **3 Severe impairment** means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days. **4 Complete impairment** means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days. **8 Not specified** means there is insufficient information to specify the severity of the impairment. **9 Not applicable** means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

Short List of Body Functions	Qualifier
b1. MENTAL FUNCTIONS	
b110 Consciousness	
b114 Orientation (time, place, person)	
b117 Intellectual (incl. Retardation, dementia)	
b130 Energy and drive functions	
b134 Sleep	
b140 Attention	
b144 Memory	
b152 Emotional functions	
b156 Perceptual functions	
b164 Higher level cognitive functions	
b167 Language	
b2. SENSORY FUNCTIONS AND PAIN	
b210 Seeing	
b230 Hearing	
b235 Vestibular (incl. Balance functions)	
b280 Pain	
b3. VOICE AND SPEECH FUNCTIONS	
b310 Voice	



b4. FUNCTIONS OF THE CARDIOVASCULAR, HAEMATOLOGICAL, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS	
b410 Heart	
b420 Blood pressure	
b430 Haematological (blood)	
b435 Immunological (allergies, hypersensitivity)	
b440 Respiration (breathing)	
b5. FUNCTIONS OF THE DIGESTIVE, METABOLIC AND ENDOCRINE SYSTEMS	
b515 Digestive	
b525 Defecation	
b530 Weight maintenance	
b555 Endocrine glands (hormonal changes)	
b6. GENITOURINARY AND REPRODUCTIVE FUNCTIONS	
b620 Urination functions	
b640 Sexual functions	
b7. NEUROMUSCULOSKELETAL AND MOVEMENT RELATED FUNCTIONS	
b710 Mobility of joint	
b730 Muscle power	
b735 Muscle tone	
b765 Involuntary movements	
b8. FUNCTIONS OF THE SKIN AND RELATED STRUCTURES	
ANY OTHER BODY FUNCTIONS	

Part 1 b: IMPAIRMENTS of BODY STRUCTURES

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

Impairments are problems in structure as a significant deviation or loss.

First Qualifier: Extent of impairment	Second Qualifier: Nature of the change
<p>0 No impairment means the person has no problem</p> <p>1 Mild impairment means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.</p> <p>2 Moderate impairment means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days.</p> <p>3 Severe impairment means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days.</p> <p>4 Complete impairment means that a problem that is present more</p>	<p>0 No change in structure</p> <p>1 Total absence</p> <p>2 Partial absence</p> <p>3 Additional part</p> <p>4 Aberrant dimensions</p> <p>5 Discontinuity</p> <p>6 Deviating position</p> <p>7 Qualitative changes in structure, including accumulation of fluid</p> <p>8 Not specified</p> <p>9 Not applicable</p>

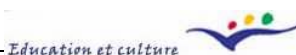


than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days.

8 Not specified means there is insufficient information to specify the severity of the impairment.

9 Not applicable means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

Short List of Body Structures	First Qualifier: Extent of impairment	Second Qualifier: Nature of the change
s1. STRUCTURE OF THE NERVOUS SYSTEM		
s110 Brain		
s120 Spinal cord and peripheral nerves		
s2. THE EYE, EAR AND RELATED STRUCTURES		
s3. STRUCTURES INVOLVED IN VOICE AND SPEECH		
s4. STRUCTURE OF THE CARDIOVASCULAR, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS		
s410 Cardiovascular system		
s430 Respiratory system		
s5. STRUCTURES RELATED TO THE DIGESTIVE, METABOLISM AND ENDOCRINE SYSTEMS		
s6. STRUCTURE RELATED TO GENITOURINARY AND REPRODUCTIVE SYSTEM		
s610 Urinary system		
s630 Reproductive system		
s7. STRUCTURE RELATED TO MOVEMENT		
s710 Head and neck region		
s720 Shoulder region		
s730 Upper extremity (arm, hand)		
s740 Pelvis		
s750 Lower extremity (leg, foot)		
s760 Trunk		
s8. SKIN AND RELATED STRUCTURES		
ANY OTHER BODY STRUCTURES		



PART 2: ACTIVITY LIMITATIONS & PARTICIPATION RESTRICTION

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

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

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

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

Note: Use Appendix 2 if needed to elicit information on the Activities and Participation of the individual

First Qualifier: Performance <i>Extent of Participation Restriction</i>	Second Qualifier: Capacity (without assistance) <i>Extent of Activity limitation</i>
<p>0 No difficulty means the person has no problem</p> <p>1 Mild difficulty means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.</p> <p>2 Moderate difficulty means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days.</p> <p>3 Severe difficulty means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days.</p> <p>4 Complete difficulty means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days.</p> <p>8 Not specified means there is insufficient information to specify the severity of the difficulty.</p> <p>9 Not applicable means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).</p>	

Short List of A&P domains	Performance Qualifier	Capacity Qualifier
d1. LEARNING AND APPLYING KNOWLEDGE		
d110 Watching		
d115 Listening		
d140 Learning to read		
d145 Learning to write		
d150 Learning to calculate (arithmetic)		



d175 Solving problems		
d2. GENERAL TASKS AND DEMANDS		
d210 Undertaking a single task		
d220 Undertaking multiple tasks		
d3. COMMUNICATION		
d310 Communicating with -- receiving -- spoken messages		
d315 Communicating with -- receiving -- non-verbal messages		
d330 Speaking		
d335 Producing non-verbal messages		
d350 Conversation		
d4. MOBILITY		
d430 Lifting and carrying objects		
d440 Fine hand use (picking up, grasping)		
d450 Walking		
d465 Moving around using equipment (wheelchair, skates, etc.)		
d470 Using transportation (car, bus, train, plane, etc.)		
d475 Driving (riding bicycle and motorbike, driving car, etc.)		
d5. SELF CARE		
d510 Washing oneself (bathing, drying, washing hands, etc)		
d520 Caring for body parts (brushing teeth, shaving, grooming, etc.)		
d530 Toileting		
d540 Dressing		
d550 Eating		
d560 Drinking		
d570 Looking after one`s health		
d6. DOMESTIC LIFE		
d620 Acquisition of goods and services (shopping, etc.)		
d630 Preparation of meals (cooking etc.)		
d640 Doing housework (cleaning house, washing dishes laundry, ironing, etc.)		
d660 Assisting others		
d7. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS		
d710 Basic interpersonal interactions		
d720 Complex interpersonal interactions		
d730 Relating with strangers		
d740 Formal relationships		
d750 Informal social relationships		
d760 Family relationships		
d770 Intimate relationships		



d8. MAJOR LIFE AREAS		
d810 Informal education		
d820 School education		
d830 Higher education		
d850 Remunerative employment		
d860 Basic economic transactions		
d870 Economic self-sufficiency		
d9. COMMUNITY, SOCIAL AND CIVIC LIFE		
d910 Community Life		
d920 Recreation and leisure		
d930 Religion and spirituality		
d940 Human rights		
d950 Political life and citizenship		
ANY OTHER ACTIVITY AND PARTICIPATION		



PART 3: ENVIRONMENTAL FACTORS

• Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

Qualifier in environment:	0 No barriers	0 No facilitator
Barriers or facilitator	1 Mild barriers	+1 Mild facilitator
	2 Moderate barriers	+2 Moderate facilitator
	3 Severe barriers	+3 Substantial facilitator
	4 Complete barriers	+4 Complete facilitator

Short List of Environment	Qualifier barrier or facilitator
e1. PRODUCTS AND TECHNOLOGY	
e110 For personal consumption (food, medicines)	
e115 For personal use in daily living	
e120 For personal indoor and outdoor mobility and transportation	
e125 Products for communication	
e150 Design, construction and building products and technology of buildings for public use	
e155 Design, construction and building products and technology of buildings for private use	
e2. NATURAL ENVIRONMENT AND HUMAN MADE CHANGES TO ENVIRONMENT	
e225 Climate	
e240 Light	
e250 Sound	
e3. SUPPORT AND RELATIONSHIPS	
e310 Immediate family	
e320 Friends	
e325 Acquaintances, peers, colleagues, neighbours and community members	
e330 People in position of authority	
e340 Personal care providers and personal assistants	
e355 Health professionals	
e360 Health related professionals	
e4. ATTITUDES	
e410 Individual attitudes of immediate family members	
e420 Individual attitudes of friends	
e440 Individual attitudes of personal care providers and personal assistants	
e450 Individual attitudes of health professionals	
e455 Individual attitudes of health related professionals	
e460 Societal attitudes	



e465 Social norms, practices and ideologies	
E5. SERVICES, SYSTEMS AND POLICIES	
e525 Housing services, systems and policies	
e535 Communication services, systems and policies	
e540 Transportation services, systems and policies	
e550 Legal services, systems and policies	
e570 Social security, services, systems and policies	
e575 General social support services, systems and policies	
e580 Health services, systems and policies	
e585 Education and training services, systems and policies	
e590 Labour and employment services, systems and policies	
ANY OTHER ENVIRONMENTAL FACTORS	

Part 4: OTHER CONTEXTUAL INFORMATION

4.2 Include any **Personal Factors** as they impact on functioning (e.g. lifestyle, habits, social background, education, life events, race/ethnicity, sexual orientation and assets of the individual).



GUIDELINES FOR THE USE OF ICF CHECKLIST

This is a checklist of major categories of International Classification of Functioning, Disability and Health (ICF) of the World Health Organization . The ICF Checklist is a practical tool to elicit and record information on the functioning and disability of an individual. This information can be summarized for case records (for example, in clinical practice or social work).

- 1 This version (2.1a) is for use by a clinician, health or social care professional.
- 2 The checklist should be used along with the ICF full or short version which is scheduled for publication in September 2001. Until then the ICIDH-2 Final Draft, full version, WHO, 2001 will serve as reference document for the ICF checklist. The raters should familiarize themselves with the ICIDH-2 Final Draft by attending a brief educational programme or self-taught curriculum.
- 3 All information from written records, primary respondent, other informants and direct observation can be used to fill in the checklist. Please record all sources of information used on the first page.
- 4 Parts 1 to 3 should be filled in by writing the qualifier code against each of the function, structure, activity and participation term that shows some problem for the case being evaluated. Appropriate codes for the qualifiers are given on the relevant pages.
- 5 Comments can be made regarding any information that can serve as the additional qualifier or that is thought to be significant for the case being evaluated.
- 6 Part 4 (Environment) has both negative (barrier) and positive (facilitator) qualifier codes. For all positive qualifier codes, please use a plus (+) sign before the code.
- 7 The categories given in the checklist have been selected from the ICF and are not exhaustive. If you need to use a category that you do not find listed here, use the space at the end of each dimension to record these.



Attachment 2

BRIEF HEALTH INFORMATION

Self Report Clinician Administered

X.1 Height : ___/___/___ cm (or inches)

X.2 Weight: ___/___/___ kg (or pounds)

X.3 Dominant Hand (prior to health condition): Left Right Both hands equally

X.4 How do you rate your physical health in the past month? Very good Good Moderate Bad
Very bad

X.5 How do you rate your mental and emotional health in the past month? Very good Good Moderate
 Bad Very bad

X.6 Do you currently have any disease(s) or disorder(s) ? NO YES

If YES, please specify: _____

X.7 Did you ever have any significant injuries that had an impact on your level of functioning?

NO YES If YES, please specify _____

X.8 Have you been hospitalized in the last year? NO YES

If YES, please specify reason(s) and for how long?

1 _____; ____ . ____ . ____ days
2 _____; ____ . ____ . ____ days
3 _____; ____ . ____ . ____ days

X.9 Are you taking any medication (either prescribed or over the counter)? NO YES

If YES, please specify major medications



1 _____
2 _____
3 _____

X.10 Do you smoke?

NO

YES

X.11 Do you consume alcohol or drugs?

NO YES If YES, please specify average daily quantity

Tobacco: _____

Alcohol: _____

Drugs: _____

X.12 Do you use any assistive device such as glasses, hearing aid,
wheelchair, etc.?

NO YES If YES, please specify

X.13 Do you have any person assisting you with your self care, shopping or other daily
activities? NO YES

If YES, please specify person and assistance they provide

X.14 Are you receiving any kind of treatment for your health?

NO YES If YES, please specify:

X.15 Additional significant information on your past and present health:

X.16 IN THE PAST MONTH, have you cut back (i.e. reduced) your usual activities or work because of your
health condition? (a disease, injury, emotional reasons or alcohol or drug use)

NO

YES If yes, how many days? _____

X.17 IN THE PAST MONTH, have you been totally unable to carry out your usual activities or work because
of your health condition? (a disease, injury, emotional reasons or alcohol or drug use)

NO

YES If yes, how many days? _____



GENERAL QUESTIONS FOR PARTICIPATION & ACTIVITIES

The following probes are proposed as a guide to help the examiner when interviewing the respondent about problems in functioning and life activities, in terms of the distinction between capacity and performance. Take into account all personal information known about the respondent and ask any additional probes as necessary. Probes should be rephrased as openended questions if necessary to elicit greater information.

Under each domain there are two kinds of probes:

The first probe tries to get the respondent to focus on his or her **capacity** to do a task or action, and in particular to focus on limitations in capacity that are **inherent or intrinsic features of the person** themselves. These limitations should be direct manifestations of the respondent's health state, without the assistance. By **assistance** we mean the help of another person, or assistance provided by an adapted or specially designed tool or vehicle, or any form of environmental modification to a room, home, workplace and so on. The level of capacity should be judged relative to that normally expected of the person, or the person's capacity before they acquired their health condition.

The second probe focuses on the respondent's **actual performance** of a task or action in the person's actual situation or surroundings, and elicits information about the effects of environmental barriers or facilitators. It is important to emphasize that you are only interested in the extent of difficulty the respondent has in doing things, **assuming that they want to do them**. Not doing something is irrelevant if the person chooses not to do it.

I. Mobility

(Capacity)

(1) In your present state of health, how much difficulty do you have walking long distances (such as a kilometer or more) without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present surroundings, how much of a problem do you actually have in walking long distances (such as a kilometer or more)?

(2) Is this problem walking made worse, or better, by your actual surroundings?

(3) Is your capacity to walk long distances without assistance more or less than what you



actually do in your present surroundings?

II. Self Care

(Capacity)

(1) In your present state of health, how much difficulty do you have washing yourself, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your own home, how much of a problem do you actually have washing yourself?

(2) Is this problem made worse, or better, by the way your home is set up or the specially adapted tools you use?

(3) Is your capacity to wash yourself without assistance more or less than what you actually do in your present surroundings?

III. Domestic Life

(Capacity)

(1) In your present state of health, how much difficulty do you have cleaning the floor of your where you live, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your own home, how much of a problem do you actually have cleaning the floor?

(2) Is this problem made worse, or better, by the way your home is set up or the specially adapted tools you use?

(3) Is your capacity to clean your floor without assistance more or less than what you actually do in your present surroundings?

IV. Interpersonal Interactions

(Capacity)

(1) In your present state of health, how much difficulty do you have making new friends, without assistance?

(2) How does this compare with someone, just like yourself only without your health



condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present situation, how much of a problem do you actually have making friends?

(2) Is this problem making friends made worse, or better, by anything (or anyone) in your surroundings?

(3) Is your capacity to make friends, without assistance, more or less than what you actually do in your present surroundings?

V. Major Life Areas

(Capacity)

(1) In your present state of health, how much difficulty do you have getting done all the work you need to do for your job, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present surroundings, how much of a problem do you actually have getting done all the work you need to do for your job?

(2) Is this problem fulfilling your job requirements made worse, or better, by the way the work environment is set up or the specially adapted tools you use?

(3) Is your capacity to do your job, without assistance, more or less than what you actually do in your present surroundings?

VI. Community, Social and Civic Life

(Capacity)

(1) In your present state of health, how much difficulty do you have participating in community gatherings, festivals or other local events, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)



(Performance)

(1) In your community, how much of a problem do you actually have participating in community gatherings, festivals or other local events?

(2) Is this problem made worse, or better, by the way your community is arranged or the specially adapted tools, vehicles or whatever you use?

(3) Is your capacity to participate in community events, without assistance, more or less than what you actually do in your present surroundings?



Attachment 3

Capacity Definition Form

(Attachment for Medical Commission for Italian Public Employment Services)

Capacity of undertaking occupational activities							
<p>Acquiring knowledge and applying it in an adequate way in different situations</p> <p>d198. Learning and applying knowledge</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum						
<input type="checkbox"/> Intermediate	<input type="checkbox"/> High						
<input type="checkbox"/> Potential							
<p>Maintaining a positive and collaborative behaviour in different relational situations</p> <p>d710 Basic interpersonal interactions d720 Complex interpersonal interactions d730 Relating with strangers d740 Formal relationships d750 Informal social relationships d760 Family relationships d770 Intimate relationships</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum						
<input type="checkbox"/> Intermediate	<input type="checkbox"/> High						
<input type="checkbox"/> Potential							
<p>Facing with a complex situation due to working rithm, environment, activitvy</p> <p>d240 Managing tensions and psychological demands</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum						
<input type="checkbox"/> Intermediate	<input type="checkbox"/> High						
<input type="checkbox"/> Potential							
<p>Undertaking group work</p> <p>d2103 Managing a single task in group d2203 Managing multiple tasks in group</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
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<input type="checkbox"/> Potential							
<p>Undertaking a task in autonomy</p> <p>d2102 Managing a single task in autonomy d2202 Managing multiple tasks in autonomy</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum						
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<p>Managing a task under supervision</p> <p>d2108 Managing single tasks d2208 Managing multiple tasks d177 Managing decisions d175 Solving problems</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Absent</td> <td style="width: 50%;"><input type="checkbox"/> Minimum</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> High</td> </tr> <tr> <td><input type="checkbox"/> Potential</td> <td></td> </tr> </table>	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High	<input type="checkbox"/> Potential	
<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum						
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<input type="checkbox"/> Potential							



Self care	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Communication	
Learning and memorizing information d310 Communicating with -- receiving -- spoken messages d315 Communicating with -- receiving -- non-verbal messages d330 Speaking d335 Producing non-verbal messages d350 Conversation d355 Discussion b144 Memory function	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Communicating coherent and clear information by speech or written means d330 Speaking d 345 Writing messages	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Communicating by other means d335 Making non verbal messages d340 Making messages by symbols and signs	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Body position	
d4153 Maintaining a seated position	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
d4154 Maintaining a standing position	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
d4102 Getting into a kneeling position d4152 Maintaining a kneeling position	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
d4101 Crouching down d4151 Maintaining a crouched position	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential



<p>d4106 Lying down d4150 Maintaining a lying position</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>d4106 Shifting the weight of the body d4108 Changing body position</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>Mobility</p>	
<p>Moving over a plane surface on one's legs d450 Walking d455 Moving d4552 Running d4553 Jumping</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>Moving around on different types of surface or on a sloping surface d450 Walking d4551 Climbing</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>Lifting (raising up an object in order to move it) d4308 Lifting and carrying</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>Mobility of arms and legs</p>	
<p>Mobility of upper arms and lower legs b710 Mobility of joints b 720 Mobility of bones b 730 Muscular force b 735 Tone of muscles</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>d440 Fine hand use d4400 Picking up d4401 Grasping d4402 Manipulating d4403 Releasing/dropping d4301 Carrying in the hand d4305 Putting down</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>d445 Fine hand and arm use</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>
<p>Maintaining feet in an immobile position d4350 Pulling with lower legs</p>	<p><input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential</p>



Physical activity and endurance	
Undertaking tasks which require physical efforts and prolonged endurance b730 Force of muscles function b740 Endurance of muscle function d430 Catching and carrying objects b4550 General physical endurance b4552 Getting fatigue	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
b750 Motor reflex functions b755 Automatic movement reaction b760 Control of voluntary movements b770 Movement patterns in walking	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Environmental factors	
e225 Endurance of weather conditions	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
e250 Endurance of noise level	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
e255 Endurance of vibration	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Endurance of artificial lighting or sunlight e240 Light	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Job/work situation (organization of work)	
Enduring time-related changes b1300 Energy level b4550 General endurance	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Endurance of working rhythm d240 Handling tension and other psychological demands b1300 Energy level b1642 Time managing b4550 General endurance	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential
Entering the work site by oneself d645 Moving using equipment (wheelchair, skates...)	<input type="checkbox"/> Absent <input type="checkbox"/> Minimum <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> Potential



Moving to work site from house d465 Moving using equipment (wheelchair, skates...) d450 Walking d470 Using transportation (car, bus, train, plane, etc.) d475 Driving (riding bicycle and motorbike, driving car, etc.)	<input type="checkbox"/> Absent	<input type="checkbox"/> Minimum
	<input type="checkbox"/> Intermediate	<input type="checkbox"/> High
	<input type="checkbox"/> Potential	

Synthesis of capacities and of potential occupational abilities

(Description of best capacities)

Potential capacities

(Description of capacity)

Capable of being improved

yes no

Means

Predictable time

(Description of capacity)

Capable of being improved

yes no

Means

Predictable time



Attachment 4: Results of Focus groups

Method

The focus groups were held in Italy and in Spain.

In each country they involved two groups: one group made up of people who work with disabled people (trainers target), and one group made up of disabled people or of their families (disabled target).

Aims of the focus group with trainers target

The focus group with training target was oriented to analyse the following contents:

- Explore the Knowledge Area: detect the trainings of the educationists (Have they a specific curriculum?), the needs of educationist and operators in terms of contents of formative and educational processes, of pedagogic theories and instruments for people with acquired disability who could return to work
- Explore the Attitudes Area: the relational and emotional skills and the behavioural styles of the educationists....
- Explore the Professional Effectiveness: describe the main practical abilities of the educationists and the main factors which are important to take into account when developing an educational programs to disabled people.

Aims of the focus group with disabled target

- Knowledge Area, that is:
 - what knowledge could be useful for disabled people to return to work;
 - what contents of an hypothetic training program;
 - what past knowledge of the person should be rescued and should be used to the best of his advantage
 - what kind of training would be adapted for the aim of returning to work.
- Attitudes Area, that is:
 - what attitudes of the disabled people should be improved to have success in the work reintroduction
 - what motivations and expectations do disabled have and in which way the motivations could be enhanced by an educational program
 - what emotional and behavioural skills should be developed in an educational program
- Professional Effectiveness: describe the main practical abilities and concrete skills which are expected to facilitate the reintroduction of disabled people to work.



Results of the focus group with trainers target (SPAIN)

Area of the knowledge

- They (the trainers) should have knowledge on the illness or situation of the pupil to be able to carry out an appropriate approach of the training. Therefore they should also know how to treat them.
- This also applies for voluntary trainers
- They should have knowledge of the labour market, new markets, new technologies, employment offer.
- They should be aware of courses that really provide possibilities of finding a job, not the typical computer course. For that purpose it is necessary to have previously done a study of the demand.
- To teach them things that really interest and attract them because they don't hope to do be able to work in the same job again.
- It is very frustrating to teach them something that they won't be able to do.
- Adapted and individualised courses (also in the cognitive area). For that it is necessary to train other skills before approaching the technical part of the course.
- Occupational therapists, social workers, etc. also need that kind of training because courses should count on them as a supporting element.
- Occupational Therapists are fundamental. They promote and improve abilities that still remain and they adapt them.
- Labour advisors and Social workers are also necessary.
- Technical qualified personnel (the trainers/teachers)
- Auxiliary nurses for those severely disabled.
- Associations should train trainers/teachers because public administration merely does it.
- They don't know if there are specific courses for trainers. Apanefa train those that will give class there. They stress to train them so they know how pupils can understand them.
- They must have clear where and with whom they are going to work, the culture of the entity, the objectives and the project in which they will work.
- They should have psychological and pedagogic abilities they should have been trained for that at university. One can also make in the associations of having affected.
- The trainers working for the National Institute for Employment request training for training disabled people. The administration should hire associations for this task .

Attitudes

- Empathy, patience, no social prejudices.
- Trainers usually come motivated by their vocation
- To have a lot of interest for the collective
- To be realistic and if there is not progress not to be depressed.
- It is a job that you cannot perform for a long time due to psychological exhaustion.
- To know how to keep the distance so that it doesn't affect them emotionally.
- Must have a strong personality



- To assume reality and to do what they just as much as they can.

Professional effectiveness

- There are almost no special training programs for disabled people trainers given by public administration. They have to learn from day to day practice and experience.
- There are no adapted paths and there is a labour effective demand in spite of the reservation.
- Trainers must be tolerant, and have a listening attitude to discover what they can do by themselves. They must also be patient and not try to accelerate the learning process. They should do individual training.
- They should evaluate developed abilities, more than acquired knowledge. Also assess interest, participation, sociability. Once working for a company, the disabled person should have a tutor monitoring their work.
- To improve the trainer's knowledge, abilities and skills, it is necessary that they are trained by the disability community, which is by societies dealing with the different conditions. They should learn on the pathology and situation of the affected people.
- To give advice and guidelines for each situation (cognitive, physical, etc). It is possible to train at the same time on different conditions.



Results of the focus group with disabled target (SPAIN)

Area of knowledge

- Redirection of their (disabled people) labour profile, if necessary.
- First to assume and to recuperate their self-esteem. It is necessary to work the psychological aspect to locate them in their new reality and accepting it. To remark which are their limits to avoid later frustrations.
- Then, to give an alternative and if he/she can work, to set itineraries otherwise, to look for resources to improve their quality of life.
- There are too many courses dealing with computers, design etc, carried out by disabled societies, recuperation centres and hospitals, ONCE. Most of the times are studied by people who in fact, do not have interest working again.
- To bear in mind the difference between vocational occupational training and training as a social resource (occupational workshops).
- Problem is when vocational training is distorted it serves as a ragbag and as there are no other resources, people are sent to these courses, which is obnoxious for students, professors, the system, etc.
- Society brings them back to reality and when they go to a company and do a test being rejected they are again in a frustrating situation.
- To establish bases and then redirect people. Then learn about what they have been working at before acquiring disability, their past and present abilities, and how to adapt the work place. This is possible in jobs related with the technology.
- To keep in mind if the pathology will evolve and the age is also important. People of 45 don't know how to look for a job nowadays because things have changed.
- Basic knowledge in computers is necessary as in general society.
- People with brain damage are very complicated to train due to cognitive and behaviour sequels at level. They mainly work in occupational workshops, if they don't have problems with hands mobility.
- Also at special work centres accept people with a high level of autonomy. Therefore candidates must have abilities to work in group, for continuous training, etc. Those who don't have serious problems are integrated in the labour market.
- The problem is to know what to do with those who cannot work in a normal job or in a special work centre but are not so bad to go to occupational workshops. They usually rotate from workshop to workshop but it is not the solution and is very frustrating for them.
- According to 1999 Survey on Disability in Spain, just 17% of people with acquired disability, improve. The remainder is stabilized or get worse and the age worsen everything. In CRMF 20% / 25% improve. Others get worse for psychological reasons.
- People with brain damage, keep knowledge but you don't know how to develop their task because they have lost social abilities.
- An example in real life, is a person that started working in a company, but needed somebody who helped him every time he went to the toilette. Nobody wanted to do it.
- In MS the problem is to have a toilette close to your working place. If you use crutches or a wheelchair is even more problematic. In MS hand mobility, is no problem if hands are not affected. In they have cognitive problems, they are trained again some abilities but the problem doesn't disappear anyway and it usually get worse.



- In spinal cord injury there are no cognitive problems but there could be psychological problems. There are patients who are very keen on their training and they specialize in specific areas achieving a high standard.
- The social, physical, and family environment is fundamental and they are always obstacles. Family overprotection. Parents are not trained in order not to overprotect their sons/daughters.
- There are no new ideas in training. There should be assessment teams to value who should benefit from training and who are not able to do so and external experts that evaluate at the end if those people are well trained.
- Right now everything deals with computers. There are people who do not like this topic.
- There have been some experiences in Extremadura with staff working for public administration who act as tutors for people with mental disability, training then for working in public administration.
- There is too many people devoted to computers. This has been beneficial for people with physical disability. Learning other languages has not been exploited and it is an interesting topic.
- Tourism for the elderly and disabled could be interesting as well. There are already private companies that are devoted to it and that can generate employment. Certifications that the environments are accessible, webs etc.

Attitudes

- If pensions are higher than the salaries offered to them, they don't want to work. There should be some kind of compatibility between pensions and wages so that people are motivated to work.
- People with MS ask for courses just to stay active, amused etc, but they not for finding a job.
- There should be some certificates that from the beginning certified that the person is capable to work now, sometime in the future or never. Maybe public administration and societies dealing with disabled are insisting in labour insertion when the collective is not really requesting it. Policies giving money have been for a long time now those aiming to labour insertion. Now this is changing and personal autonomy is the main objective.
- People with brain damage are highly motivated in the beginning, they are not aware of their limitations and it frustrates them when they cannot be integrated. They think that is only a matter of time and then they will return to the same life. They have capacities, but neither social nor emotional abilities.
- The families need a discharge but a job is not the way.
- There are no resources and there should be resources for each case: special centres for brain damage, spinal cord injury, etc.
- It is counteractive to try to normalize what is not. There are centres where all of them are together and it is not possible to train this way. Constantly with each student it is necessary to change the method of working, during the same lesson. They have different working rhythms, etc. They should be together for similar capacities, although they have different pathologies.
- Trainers should take a specific course on the collective they are going to teach. That is training courses for training. They should learn what aphasia is, etc. behaviour problems, incontinence, etc.
- Disabled people should learn how to face working in team, how to get to the place where they work (transport).



- A proposal could be “training flats” the same thing as supervised flats,
- To develop other abilities. The society of Spinal Cord injury, have tutorials given to by those who have been with this condition for many years to newly injured: Couples to couples, etc. so that they see that you can go out for dinner, they teach them how to move around, getting a taxi, etc.
- Those recently injured staying at Toledo Hospital for paraplegic think that everything seems enough adapted and that there are a lot of resources for the disabled people. When they leave the period of rehabilitation and they return home they realise that reality is different.
- They find physical, social, and family barriers, as well as their own psychological barriers.
- Ours is an immature society that excludes and discriminates the different.
- Awareness is reached through sanction (smoking is an example). Companies not hiring disabled people as the Law has established, must be sanctioned to. LISMI and other laws are not applied because there is not will of applying it.
- Spain at the end of the queue of Europe regarding social and labour integration. It would also be a good idea if EU also sanctioned countries in this sense.
- Exchange of European disabled. A sort of Erasmus.
- To reward to companies observing the laws. There should be a seal and a certification to the excellence in the disabled people integration. Companies than have achieved this certificate should be favoured when contracting with public administrations, etc.



Results of the focus group with trainers target (ITALY)

The participants showed a particular interest in the contents of the *focus group* and played an active and stimulating interaction.

The themes of the focus have been analysed on different levels:

- Problems concerning disability and disabled care;
- Social and normative context
- Services network and organization
- Italian employment context, employment culture and employees awoken of the problem.

One concept has been clarified during the discussion: the term “employment” should pass through social reintroduction; it is not strictly job finding or job maintenance, but it is a global intervention which involves all life sphere of the disabled person.

Nowadays employers have no motivation in introducing disabled people to work, even if the law gives clear directories in this sense; they prefer to pay a fine. There aren't incentives or gains for the employers. An occupational program shouldn't start from a “job finding” perspective, which could frighten the employers.

There is also the problem of the costs of an occupational project for disabled target: many past experiences have proved the failing of educational programs that don't match with occupational resources and that are not responding in their contents to real occupational needs. This model should be abandoned in order to create a more effective link between educational programs and occupational opportunities (involving enterprises and employers in the program).

Some rare experiences could be taken as an example (as, for example, McDonald's programs for Down Syndrome): they contribute to divulgate a new perspective and a new attention to disability problem.

Knowledge Area

To develop an educational program aimed to employment reintroduction of disabled people it is recommended to take into account:

Related to the operator/ educationist / trainer:

- The competence to deal with medical problem (i.e. decubitus ulcers; catheterization, feeding...)
- The competence on medical aids and helps
- The psychological aspects linked to acquired disability related to a new self image and corporeity of the disabled person
- The competence on normative situation
- The attention to take abreast of new laws
- The level of compliance of the person and of his family to the program



Related to the disabled person:

- his level of adaptation to disability
- his capacity to accept suggestions and help
- his economic condition
- his social and familiar role

Related to social context (occupational context, services, politics...) there is a need to develop:

- Consistent data bases of people with acquired disability
- Interrelated networks that share information, organize meeting, match methodologies and approaches to the problem
- Information about accessibility to services
- Protocols that state procedural patterns, links, responsibilities of different services

Attitudes Area

It is useful to organize a multidisciplinary network who cares of the disabled person and of his/her family since traumatic event or disease occurs. This network should assist them with a project in order to help them to face with disability and to adapt to many changes. Nowadays there is a lack of psychological interventions which could help during this process. The disabled person is not as he was: he generally suffers a “cut” with his past life and now he faces with new needs and big troubles.

Related to the operator/ educationist / trainer

- Relational competence
- Listening capacity
- The ability to manage a sustaining relationship over the time
- The ability to work in group, in team
- The competence to assist a global reintroduction (on a psychological, emotional and social level)
- The competence to assist the person in the emotional and cognitive match between past and present
- To be aware of the network around him and of the rules of each stakeholder in the network
- To be tolerant of the disabled person’s rhythms (to work out his bereavement, his depression...)
- The capacity of avoiding a relationship based on power and dependence

Related to the General Social Context

- The capacity to reduce prejudice and stigma on disability
- The capacity to reduce disparities



- The culture of empowering disabled resources rather than rising up their residual capacities
- The employers attitude to receive disabled persons and to sustain the project of occupational reintroduction

Professional Effectiveness Area

Related to the trainers:

- be aware of the personal role and of other professional figures role
- know how other services work, how to contact them, what paths to access to them
- keep abreast of new changes and developments of the services
- assist employers in a educational-occupational program for disabled people
- start with interests and motivation of the disabled person, not only considering the perspective of his residual resources
- be capable in giving clear information
- participate to supervision meetings
- the educationists have the role of tutoring, working in a network or in a group in contact with or entering the enterprises (or other occupational environment)
- to create conditions to adapt the environment (house organization, architectural barriers...)
- to help disabled people by an orientation action which could facilitate him to achieve awareness on his expectations and motivations.
- The ability to mediate with the social and familiar context of the disabled person

Related to social and employment context:

- to develop distributed and territorial services: at the moment there is a lack of opportunities and the main services are home assistance and medical aids delivery
- to enhance the number of occupational opportunities
- to develop inter-institutional initiatives to empower links and dialogue among institutions
- to develop occupational reintroduction of disabled people starting from gains for the employees, who should be motivated to help the disabled person
- to reduce bureaucracy and complex organization of the services in order to facilitate accessibility to occupational reintroduction programs
- to develop awareness in work environment
- to develop links and protocols between educational programs and occupational environment, making up working groups which could involve social workers, educationists, employers and other professional figures that could give an help in the educational-occupational program
- to facilitate the occupational reintroduction program by stages
- to eliminate disparity and differences in intervention for disabled people
- to have care of architectural barriers demolition
- to assist operators, employers, educationist with a supervision all the process long



Results of the focus group with disabled target (ITALY)

The participants showed the following specific emotions and behaviours while interacting in the focus group:

- Fear and uncertainty: disability determines instability and difficulties in planning the future
- Difficulties in communication among different levels of disability: each situation has its own specific needs and it is difficult to match a severe disability with a lighter one.
- Difficulties in communication among different typologies of disability.

In the *focus group* one concept was particularly stressed: an educational program aimed to reintroduction to work shouldn't be a pre-packed educational program; it rather could be more useful to develop an "*ad personam*" educational program, taking into account some important factors which are related to the singular person and situation.

The debate was oriented to the following main contents:

- a. in the Knowledge Area: the topics of an educational training and of an educational approach
- b. in the Attitude Area: the psychological aspects of the disabled person and of his/her context of life, which are important to be explored for the development of a reintroduction-to-work project
- c. in the "Professional Effectiveness": social and political elements should be improved to facilitate the disabled reintroduction to work.

Knowledge Area

To develop an educational program to reintroduction to work it is not recommended to start with its contents, but it is better to follow these suggestions :

Related to the disabled person

- Interests
- Actual capabilities
- Rescue his/her past experiences, to address on them the educational program

Related to the educationist/trainer

- Be trained on the different disabilities

Attitudes Area: the disabled person and his/her life context

Related to the disabled person

The disabled person adaptability to acquired disability affects his motivation and his will to exit from a severe situation. This element seems to be essential for a successful reintroduction-to-work project.



Acquired disability is a traumatic event, which could get one person and his family into a never-lasting drama.

This traumatic event could give rise to a depressive state and a disadaptive disease.

A disabled person could suffer an affront to his/her pride. Sometimes frequently occurs a "cut" with past life and past habits; even past friends tend to "disappear". The isolation enhances the personal problems and difficulties.

The disabled person could be inclined to live apart, to have difficulties with accepting to get out, because of a lack of motivational stimulus.

The most important effort should be oriented to a careful and deep evaluation of the person's psychological status: this analysis could give the elements in order to develop a project having the purpose to reduce the isolation status.

For this reason it is recommended to develop "ad personam" programs (far from generic and heterogeneous programs) and to evaluate the following aspects:

- the level of the disabled person's adaptation to the disability status;
- the level of the disabled person's family adaptation to the disability status;
- the psychological status of the disabled person, which include:
 - a. the mood (good or bad mood, steadiness of mood)
 - b. the will and the motivational state
 - c. anxiety or depressive state
 - d. cognitive disorders (in vigilance, attention, memory, language...)
 - e. family care and assistance
 - f. care and assistance by friends or social network (and the disabled person's will to trust in and to rely on external help)
 - g. the disabled person's capability to face with other disability situations
 - h. the potential capabilities to improve.

Related to the trainers

- Use an empathetic approach
- Be creative to find a way to establish a confident relationship with the disabled person

The Professional Effectiveness Area: the social and political context

Related to social and political context

To realize a successful reintroduction-to-work project of disabled people it is useful to make real some changes in social and political organization.

In particular the following aspects should be improved and developed in the Italian social context:

- to create an integrated network of services aimed to disabled reintroduction to work



- to evaluate the occupational opportunities
- to avoid overlapping of services (in Italy the risk of overlapping is related to INAIL services, Lex 68/99 commissions, Public Employment Centres)
- to create clear and accessible paths for reintroduction-to-work
- to make clear and available work opportunities
- to develop training of the employers to awaken them on disability problems of reintroduction to work
- to awaken public opinion on disability problems and needs.

Related to the educationist

- Use a consistent method and different training tools
- Work with the disabled person, spending a long time with him/her, in order to find out his/her attitudes and potential capabilities.
- Evaluate working opportunities to develop a specific training program.



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