



EUROPEAN COUNSELLOR Curriculum

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INTRODUCTION

1. BASKI European Counsellor

The European Counsellor Training is a qualification programme for professionals in the social/educational/psychological sector and with experience in the fields of counselling, assistance or disability care. Personal requirements include good communication reflection skills; flexibility; and they should show respect acceptance towards people with and without disabilities.

The trainees should gain basic knowledge from the group dynamics sessions for people with disabilities, special training and coaching skills; and, they should obtain concrete support for the assistance of Basic Skills Training groups.

2. Process

As defined in the European Counsellor Curriculum, modules are worked on in linear together with the participants.

The intensity and duration of the various contents depend on the participants' previous knowledge and basic training. Breaks, tasks (e.g. theoretical work at home, collecting practical examples), and reflection time are to be arranged. And remember: Self-determination is a determinant of success in every respect, also during the schooling process!

3. Implementing Contents

Here we aim to revise and work on the theoretical contents and link them to the BASKI Training and BASKI Coaching.

In this context, the connection of the content, exercises and methods with the BASKI Training is of prime importance (see: BASKI Training Curriculum on the website: <http://www.basic-skills-training.org>).

4. BASKI-Basics

Participants become familiar with the general framework of the BASKI topics such as basic attitude, acceptance and equal participation of all involved. These topics are explored and experienced during the course of the training.

5. BASKI-Methods

We recommend the introduction and trial of many different methods and exercises which the participants can then apply in their future work with BASKI Training groups in supported housing schemes, day centres and sheltered employment programmes. The exchange of practical experiences and work on actual training- and coaching situations are central aspects of the training. The participants should actively and constructively look into different coaching topics. It is therefore the duty of the trainer/group leader to offer role-playing examples of "worst-case scenarios" so that the participants can gain practice in this area during the training.

6. Self-Awareness/Reflection

The self-reflection abilities of the participants are extremely important and should be given enough time to develop during the course of the qualification process.

7. The Role of Parents and Relatives

The learning- and development process aimed for in the BASKI Training for disabled individuals often triggers strong emotions, which may also affect the family systems of the participants. It is therefore important to prepare and support the carers within the framework of the BASKI Coaching, so that they in turn, can offer appropriate parent support.

8. Recommendations for General Framework

- Smaller training groups of ten participants (maximum)
- Well-equipped rooms with a comfortable working and training environment (i.e., flip charts, overhead projector, CD-player, etc.).
- The duration of one teaching session: 50 to 60 minutes
- As it is a part-time course, the training should be offered in blocks.
- When developing the learning contents, interdisciplinary knowledge transfer pertaining to practical use should be taken into consideration
- The handouts for the individual sessions should complement the learning contents and advance knowledge.
- The participants should be included in the process as much as possible as experts in their own right (as lecturers).
- The modules and sessions can be changed, expanded or shortened according to the previous knowledge and experience of the participants
- The learning methods and materials should stimulate the learning process.

MODULES

Module I	"Reflection on self-determination and heteronomy"	HERMES Author: Maria Apostolou www.amea.gr
Module II	"Understanding the role of the carer"	HERMES Author: Maria Apostolou www.amea.gr
Module III	"Appointment of venue and environmental analysis of the institution"??	ÉFOÉSZ Author: Szabo Kinga www.efoesz.hu
Module IV	"Managing daily support"	ÉFOÉSZ Author: Szabo Kinga www.efoesz.hu
Module V	"New media in daily support"	IAT Author: Ileana Hamburg www.iatge.de

MODULE I

REFLECTION ON SELF-DETERMINATION AND HETERONOMY

1. Learning Objectives

- The participants should be able to appreciate that people with disabilities have a right to self-determination and they should be motivated to act accordingly.
- The participants should be able to describe the four models of disability (traditional, medical, social, holistic) and distinguish the differences between them.
- The participants should be able to understand the concept of heteronomy theoretically; and moreover, appreciate how this way of thinking influences the lives of people with disabilities.
- The participants should be able to explain and utilise the theoretical concept of person-centred planning in relation to the concept of "Accompagnement".

2. Learning Contents

Self-determination is a term which is widely used nowadays, with a social or political meaning attributed to it, depending on who is making use of the term. When comparing this concept to heteronomy, we can look at the implications in people's lives caused by these two opposing ways of thinking and acting.

Issues concerning the different perceptions on disability will be examined, and how these have evolved to a new paradigm, which acknowledges the right of choice and decision and also reminds of the responsibilities and obligations that come with independence.

According to Field, Martin, Miller, Ward and Wehmeyer (Field et al., 1998):

"Self-determination is a combination of skills, knowledge and beliefs that enable a person to engage in goal directed, self-regulated, autonomous behaviour. An understanding of one's strengths and limitations together with a belief in oneself as capable and effective are essential to

self-determination. When acting on the basis of these skills and attitudes, individuals have greater ability to take control of their lives and assume the roles of successful adults in our society' (p. 2)

It is interesting that this definition focuses both on the skills and the attitudes which need to be developed. The empowerment of the personality, the strengthening of self-esteem, is in the core of every effort towards independence.

Self-determination has been described as an intervention and an outcome. Its components are: (a) choice-making, (b) decision-making, (c) problem-solving, (d) goal-setting and attainment, (e) self-advocacy, (f) self-efficacy, (g) self-awareness and understanding; and, (h) self-observation, evaluation and reinforcement. (SDSP, 9/2/2006)

Looking at the four models of disability, the traditional model relates to the religious and cultural beliefs of society while the medical model is relevant to the medical concept of disability; there is also the social model and finally the holistic model, which involves aspects of all the other models.

People attribute diverse roles to people with disabilities according to their perception of the world, their social organisation and other factors. The traditional model postulates that there is no scientific knowledge on which attitudes can be based rather the problem of disability is subjective and personal.

The medical model looks at the phenomenon of disability as a personal problem caused by ailments and in need of medical help. Professionals are in charge of any intervention which aims at the amelioration of the different behaviour of the person. In this sense the rehabilitation of damages (sic) is more important than the person's needs. Professionals use assessment tools to measure damages, and decide on people's living conditions, their education and working situation. There is no place for decision-making; their education, rehabilitation and vocational programmes are organised by others; their lives are characterised by heteronomy and dependence.

On the other hand, the social model looks at disability as a synthesis of limitations created in the social context and not as the characteristic of one person. In other words, it is the society that needs to change, not the person. This model led many countries to change their social policies and develop schemes for social and economical integration while encouraging people with disabilities to participate in the planning and implementation of such policies.

Finally, the holistic model recognises disability as a situation of dynamic interaction between the condition of health and other personal and environmental factors. This model is a synthesis of the medical and the social models, using the most positive aspects of the two. Within this model, the aetiology of disability, i.e. intellectual disability or sensory impairment, is not as important as the description of the level of functionality and participation of each person in the community. In this sense, the person is viewed in a positive way and the barriers set by social restrictions are acknowledged. The concepts of functionality, activity and participation are predominant and relevant to everyone regardless of the condition of their health.

(Anna Stavrakopoulou in Association HERMES, 2005)

Within the traditional and medical model of disability lies the concept of **heteronomy** as mentioned: it presumes that people with disabilities cannot make choices and decide for themselves due to the constraints that disability imposes on them. Other characteristics of the heteronomy concept:

- People are determined by what they cannot do
- Professionals decide what is best for the person. This is an ongoing situation which has led to "learned helplessness", low ability to react and the acceptance of other people's decisions concerning the lives of people with disabilities.
- Funds are allocated to services, not to people
- People do not choose the services that they need
- There is no emphasis put on communication as means of active choice making. The Foundation for People with Learning Disabilities (UK) run a two-year programme called "Choice Initiative" with the aim of showing that, with the right assistance, people with high support needs can express their wishes and make changes to their lives. The programme found that in order to start considering issues of choice, it is important to establish a means of communication; in practice, informal and unstructured systems of communication such as verbal and non-verbal cues, voice tone, body language, facial expression, eye contact etc. (Hazel Morgan, 9/2/2006).
- Lifestyle is ruled by financial and functional limitations

In addition to these, it has often been the case that people's own negative self-image was reinforced by damaging relationships which they have had with others in their lives or by punitive measures imposed on them. This has been allowed to happen in the context of a service that takes control over people's lives, but are unacceptable in the context of a service which values autonomy and self-determination and promotes positive "included" identities (Ramcharan et al., 1997).

Self-determination is also viewed in the context of the organised society. In the USA, the States follow the National Program Office on Self Determination (National Program Office on Self Determination, 9/2/2006) which puts emphasis on the following principles:

- Freedom to exercise the same rights as all citizens
- Authority, i.e. control over their funds. For example, in Delaware County, Ohio (USA) (National Program Office on Self Determination, 9/2/2006) they postulate that *'when we speak of changing the disability services systems, we define change in terms of the behaviour of the people served instead of the behaviours of the systems. While a service system cannot cause people to be self-determined, it can provide the opportunities and supports that encourage self-determination. We can and should evaluate the behaviour of the service system and correlating indicators of the individual self-determination to find which system changes increase the desired changes and which do not'*. This means that necessary steps

should be taken in order to enhance self-determination, as in people with disabilities this does not happen automatically.

- Support, i.e. organisation of resources determined by the person with disabilities
- Responsibility, i.e. the regular obligations of citizens

In this context self-determination concerns mainly the control over funding, independent living arrangements as well as the rights and responsibilities of a citizen with disabilities.

The constraints imposed on people due to medical and environmental conditions have a direct effect on the development of their personality. Moreover, not having control over their lives (heteronomy) results in low self esteem and learned helplessness. "Empowerment" is a notion which "consists of two basic freedoms: freedom of avoidable and unnecessary constraints, and freedom to develop one's human potential" (Ramcharan et al., 1997, p. 224). "This freedom can be achieved by the enhancement of competence and social image, the removal of constraints and by mobilising voluntary commitment and collective action" (Ramcharan et al., 1997, p. 225). People are encouraged to get involved in a process of personal change, where they are challenged to question their attitudes and ways of thinking and acting. This leads to a greater level of understanding of one's own actions as well as taking responsibility for one's life.

Professionals have developed concrete methods in order to facilitate their work with people with disabilities. First, we refer to person centred planning (Sanderson in Lacey & Ouvrey 1998) as an approach which aims at discovering the individual's preferred lifestyle and how this can be achieved. And secondly, we would like to mention the method of "Accompagnement" which was first developed by the organisation "CARAT" in Belgium and followed by IME AUTAN VAL FLEURI and SASP in France as well as Association HERMES in Greece, CERCI in Portugal, AMICA in Spain etc. Theoretically, "Accompagnement" follows the concept of normalisation (Wolfensberger) which refers to the enhancement of the social roles undertaken by people with disabilities and, practically, works with them in order to reinforce them in the process of taking control over their lives. Basic Principles of "Accompagnement":

- respect of the person
- work on communicating with the person
- support the person in the achievement of his/her goals
- respond to the needs of the whole person
- work with the person, not instead of the person
- have faith in the abilities and the potential of the person

Finally, SABE (Self Advocates Becoming Empowered) (in Lacey & Ouvry, 1998) postulate that in order for self-advocacy become possible the following should exist:

- use of communication
- access to information

- practise in choice-making
- exposure to a range of relationships

It is evident that self-determination is a complex notion and has different parameters that institutions as well as carers and clients need to look at. However, the fact that professionals are taking the people's right to live the life they choose into serious consideration and are willing to enable them to realise their dreams, is already a very positive step.

3. Teaching Methods

The aim is to involve people in the process of reflecting on the matter of self-determination and heteronomy. It does not concern knowledge only, but also refers to the changing of attitudes. Therefore the methods that have been selected require active participation.

- Brainstorming
- Case studies
- Role-playing
- Group work
- There may be the case where a group of participants is particularly resistant to the changing of attitudes; here other methods may be considered, such as group counselling or group therapy. Methods to address deeper issues that may consequently affect the work of staff at an institution.

4. Teaching Material

The teaching material will follow the standards of adult training and the basic principles of "Accompagnement"

- Flip chart (to collect group work)
- Hand-outs (main points, articles)
- CD-ROM
- Literature

MODULE II

UNDERSTANDING THE ROLE OF THE CARER

1. Learning objectives

- The participants should be able to define the role of the carer
- The participants should know the principles which guide the relationship between the carer and the person with disabilities
- The participants should be able to make use of the newly acquired knowledge in their work
- Personnel in psycho-social counselling, i.e. participants in training (European Counsellor Curriculum), will work as members of a number of teams and within organisations. They must be able to demonstrate an understanding of the roles of carers and a respect for the knowledge, skills and experience they bring to a team and organisation. They will need to demonstrate strong interpersonal skills and an open and non-discriminatory approach to professional working relationships with the carers in order to enhance the changing of attitude and to assist them during the BASKI development process.
- Participants should demonstrate a commitment to ensure an open and non-discriminatory professional working relationship

2. Learning contents

(The carer is referred to as "she")

A carer is someone who provides regular and substantial care to a person with disabilities but also someone who accompanies the person in achieving their goals, wishes and dreams. People who undertake these tasks may also be called care workers or care assistants and work in sheltered workshops or supported housing schemes; there are also trainers or educators who work closely with people with disabilities and may undertake extensive responsibilities e.g. supporting the person in their daily routine, meals, personal hygiene, etc. In the context of the Basic Skills Training Model, the "carer" is the professional who works with people with disabilities in a broader sense. Furthermore, one needs to acknowledge that the carer is a person who plays an important part in the life of an individual with disabilities. She shares the life experiences of the person with

disabilities and often acts as an advocator, facilitator and communicator. Therefore, the relationship which is formed is indeed very strong.

The roles and responsibilities of a carer may be to:

- Help people with a learning disability to access ordinary services
- Provide a health care service that includes education and information
- Give advice to family, carers, teachers and other professionals
- Have and share knowledge on various issues.
- Provide support and strategies regarding the behaviour and development of people with disabilities

Looking at this list one realises the diversity of tasks that carers are asked to fulfil in areas which are crucial for the person's well-being. Therefore they need to develop their own skills and capacities as well as increase their own self confidence and self esteem.

According to the approach of "Accompagnement", the relationship between the carer and the person with disabilities needs to be **equal, honest and qualitative**, characterised by **respect for the person, confidentiality** and **trust**. [*The method of "Accompagnement" was first developed by the organisation "CARAT" in Belgium and followed by IME AUTAN VAL FLEURI and SASP in France as well as Association HERMES in Greece, CERCI in Portugal, AMICA in Spain etc. Theoretically, "Accompagnement" follows the concept of Normalisation (Wolfensberger) which refers to the enhancement of the social roles undertaken by people with disabilities and, practically, works with them in order to reinforce them in the process of taking control over their lives.*]

Carer and client, the person with disabilities, are involved in an interaction with the aim to communicate and through this communication fulfil the client's needs. The interaction is based on certain principles, such as: a.) to respond to the needs of the whole person, b.) to work with the person, not instead of the person, c.) to have faith in the abilities and the potential of the person, d.) to avoid labelling. It is also based on the client's and carer's experiences as well as on the contract (educational or other) that the two parties have formed (Association HERMES, 2005).

Their form of relationship is also relevant to the principles of the therapeutic relationship in the person centred approach (Carl Rogers) which involve: non-directive encounter (the client sets the agenda), unconditional acceptance (non judgmental), empathetic understanding (looking at things through the other person's perspective) and authenticity (real relationship).

In order for her work to be effective and fulfilling, the carer has to act on different levels. She needs to:

- Be empathetic and authentic (as mentioned)
- Be aware of her own abilities and limitations
- Be emotionally available to the client

- Have a dynamic personality, in order to act independently in the relationship
- Feel secure enough so as to allow the client to act independently
- Be able to communicate to the client feelings of acceptance
- Be able to acknowledge to the other person the ability to change and relate to them accordingly.

As John O'Brien points out:

"Discovering and honouring people's choices in new contexts calls for important and difficult changes. Both those choosing and those assisting choice assume new risks and face new uncertainties as they explore new roles and responsibilities. Unless those involved can build relationships strong enough to create the trust and the communication flows necessary to negotiate the necessary flexibility to learn new ways, opportunities for choice will be stunted and so will people's lives" (Everyday Lives, Everyday Choices, 2000).

And indeed it is true that in order to establish communication it is not enough to use the right signals but also to have a trusting relationship which enables people to confide their wishes and dreams.

In this process carers need to be supported as well. Feelings of frustration or sadness may arise because of the restrictions that people with disabilities experience. The carer needs to be aware of these feelings and be able to express them. In her work the carer matures together with the client, as she takes part in the process of change. Supervision and collaboration in the multidisciplinary teams usually enhance good practice and also support carers through strenuous periods.

It is true that one of the most important outcomes of BASKI Training is the enhancement of good practice, which involves all the aspects that have been analysed. In order to achieve this, it would be necessary to make use of teaching methods, which involve the trainee actively, such as role-playing and group work. Moreover, the coach in an institution would need to give feedback to people while they are working on the project, in order to show them their actions. Attitudes are difficult to change since one may understand something cognitively but the way one speaks or addresses the other person may still reveal the old way of thinking.

In the Basic Skills Training Model concept it is explained that *"the staff responsible for the participating group are to be strengthened and supported during the development process, and also coached and counselled with reference to self-determination tendencies, legitimate participation and client comments"*. Furthermore, *"the respective trainer and coach adopt a model and support function for the clients/ staff with regards to didactic methods and cooperation in mutual environment"*.

In BASKI - Coaching good practice should be pinpointed and the coach should have regular meetings with the staff while the project is running so as to be able to:

- Reflect on the behaviour
- Highlight positive aspects
- Show the progress that is taking place
- Encourage people to adopt alternative ways of communication
- Assist them in recognising old patterns of behaviour and in the process of change

However, one needs to remember that carers are members of a multidisciplinary team who work closely with each person with disabilities. The coach should support the carers as members of this team in their institution as it is in those teams that the whole philosophy and gist of the institution is formed and circulated.

Also, teams are places where people:

- Disseminate information
- Organise work plans
- Set short- and long-term goals
- Assess and evaluate

To conclude, it is useful to look at the role of the carer from different angles, i.e. in relation to the person with disabilities, as part of a multidisciplinary team, as a staff member of an institution, so as to be able to appreciate the complexity of her work and offer adequate support.

3. Teaching methods

The methods that have been selected require active participation in order to enhance the changing of attitudes.

- Brainstorming
- Case studies
- Role-playing
- Group work
- Group counselling and/ or group therapy by trained therapist if necessary

4. Teaching material

The teaching material will follow the standards of adult training and the basic principles of "accompagnement"

Flip chart (to collect group work), Hand-outs (main points, articles), CD-ROM

Internet resources ,Additional reading material

MODULE III

APPOINTMENT OF VENUE AND ENVIRONMENTAL ANALYSIS OF THE ORGANISATION

1. Learning objectives

After this module the trainee should be able to assist personnel in the disability sector with best-placement issues, and conduct ecological assessments to determine service and intervention needs.

2. Learning contents

2.1. Introduction

This training unit is going to focus on four main topical areas, as follows:

- I. Rights, needs and desires of people (children/adolescents/adults) with disabilities
- II. Independence, self-management, self-determination as objectives
- III. Socialisation and social environments
- IV. Contact management with institutions

2.2. Main Part

I. Rights, needs and desires of people (children/adolescents/adults) with disabilities

Formal and informal, cultural and institutional influences

Children with (and without) disabilities first come into contact with their family environments. Local and cultural influences, personal beliefs form the attitudes of parents and of communities regarding the acceptance and handling of the situation of having a child with a disability. Schooling and formal educational institutions have also differed throughout cultures and history in their philosophies and caring, support of the socialisation of children with disabilities. The opportunity to work, and the quality of the workplace also play an important role. Residential and community life, social relationships and friendships substantially form the personality and competence of people with or without disabilities. Prevention of secondary disabilities through negative influences is an important rehabilitational goal, as is remedial work with already existing disabilities.

Human rights, the history of the civil rights movement

Basic human and civil rights are coded in the constitution of each country. Some civil right movements also declare human rights that may influence formal legislation. The principle of equal participation and normalisation has emerged from civil right movements through activists advocating for the rights of people with disabilities. Initially activists with physical disabilities fought for their rights - but later, all disability groups, incl. those with intellectual disabilities were represented by advocates. Ed Roberts has been a leading figure of the movement in the USA; together with other activists he has influenced changes in lifestyles and legislation (Americans with Disabilities Act). Civilian movements initiated most of the formal changes that led to a better quality of life for people with disabilities. - For detailed information and for your local history, please refer to the literature.

Involvement and influence of parents, educators, service providers

People with disabilities need more intensive support in the early years of their lives, and typically remain longer with, and rely upon, their families than normally developing peers. Thus, families have to be supported as a unit, and family members (parents, grandparents, siblings etc.) have to be actively involved in planning and interventions. Families have to be empowered to appropriately care for their family members with special needs. Professional early intervention services, as well as well-planned special education services are very important. In addition, families often get involved with service providers from NGO organisations who help them overcome crisis situations and provide the opportunity to share experiences with families in similar situations.

Theoretical and practical foundations of the normalisation principle

A long history of attitudes in society towards people with disabilities shows several stages; from total exclusion through to acceptance, protection and (segregated) overprotection, to the idea of general inclusion. Today, gears have been shifted from protective support to the idea of equity, viewing every person as a partner and citizen with equal rights. Instead of norms, we look at personal values and strengths/weaknesses, individual potentials and needs. Social inclusion should reach a level where the lives of people with disabilities resembles the "average" norms lived and accessed by all citizens. Services should be aimed towards assisting people with disabilities in achieving maximal possible independence, choice and decision-making, participation in community life, education and (vocational) training, work.

II. Independence, self-management, self-determination as objectives

Development/training of self-management skills

The training of self-management skills begins in the family: it is important that parents have the courage to "let go" and loosen the overprotective environments of their children with special needs. A certain degree of independence is needed if self-care and self-determination skills are to be taught. Being able to experience the consequences of their acts lets children learn the rules of social coexistence, of how far one is expected vs. allowed to go (i.e., to live within a framework of rights

and responsibilities). Real participation in natural environments and early independence are key factors.

Community involvement, functioning in natural environments

Participation in community life (leisure, education, work) should occur in an inclusive manner, without segregation, stigmatisation, or any kind of discrimination. The focus of inclusion should be real participation and not solely physical proximity. Collegial relationships and friendships are important in forming real and functional social networks. Help may be needed with mapping out personal interests and means of sharing those with others having similar interests, by means of social skills training, augmentative and alternative communication, transportation, time management, etc.

Legal issues of self-determination vs. dependence of people with disabilities

People with disabilities enjoy the same equal rights as all other citizens in the light of the normalisation principle, but they may not have the knowledge and abilities necessary to actually enforce their rights. Law enforcement and advocacy services are necessary to map out opportunities, resources, and to access services and activities. In order to be able to make use of one's rights, one needs to have a clear mind and insight into one's own actions. If such insight is limited, the free action potential of a citizen may need to be limited and exercised by an officially appointed entity. (Please refer to the professional literature for a given country's individual legal regulations.)

Organising the right amount of support (preserving dependence involuntarily)

Support services can be offered from a professional point of view, but only those services can be actually realised that are accepted and agreed on by the client and/or his/her family. The support of those in the client's everyday environments plays a key role to the success of any intervention. Another important point is that levels of support have to be carefully matched to real needs. Too much support is just like overprotection: it perpetuates dependence and hinders the development of skill maturation. Thus, progress has to be monitored and programme adjustments have to be made on a regular basis throughout an intervention programme to ensure optimal and maximal outcomes.

Motivation of personal development, competence training

If a person has an optimal frame of independence, he/she has the chance to experience his/her own competence with everyday skills and tasks. It is important to organise and offer community-based services through which people with disabilities can participate in shorter or longer training units of specific skills, and/or opportunities for social exchange. Lifelong learning and development should be an accessible ideal to people with disabilities as well. Information about opportunities and support of participation should be made available. Also, persons with disabilities, competent in given areas, can become peer trainers, both in formal or informal settings.

Adult education, vocational training, (supported) work

In supported work in the competitive employment setting, it is important to not only train and support a client with special needs, but also the personnel, directors, supervisors and future colleagues of the employee. Special technical or scheduling supports may need to be provided, crisis management

interventions need to be taught, and health and safety issues have to be discussed. Only such cooperation leads to a satisfying work environment for both employers and employees.

III. Socialisation and social environments

Family life, family supports, limitations in the process of personal maturation

In many cases, families with children who have special needs experience prejudice and - misunderstanding from their communities. This may lead to social isolation. Parents can be overwhelmed with care responsibilities, frustrations and tensions may develop. Parents may have more contact with professionals than friends and family, which further deepens isolation and dependence. In such a setting, socialisation and personal maturation is limited, and emerging limitations and deficits may decrease the chances of healthy social maturation even more as the gap between typically developing peers and family units becomes more and more obvious. This situation should not be perpetuated - it is the responsibility of the early intervention service provision systems to fight against such processes in order to maintain a healthy environment for social development.

Support systems promoting independence

Because each member of society (with or without disabilities) should equally be able to access services and activities in both professional and private life, people with disabilities should be given the opportunity (and appropriate means of additional support) to make decisions in questions concerning themselves as autonomous beings. In order to access information and services, people with disabilities may need forms of individualised support. Especially, transition services may be necessary to ease the transition from school to work, and from more institutionalised towards more independent living.

Support networks, local accessible service provision

Service provision on the individual level should be local, and preferably take place in the most natural environments. Professionals have to be highly trained, and have to learn how to cooperate both with primary clients, and with family members and/or community members in other fields (~ work, social services, residential and leisure activities, personal aids).

Cooperation of service providers to achieve optimal support

A particular service provider needs to cooperate with other agencies and organisations for optimal project outcomes and seamless service provision to clients. The service manager has to be able to objectively evaluate his/her team's effectiveness and limitations, and he/she has to accept cooperative work circumstances with the most competent experts - who need to be professionally coordinated across service agencies and institutions.

Building of social contacts, friendships, interest-based relationships

It is important that education and leisure activities be provided with peers. Real social participation has to be aimed for vs. simply 'being in the same surroundings together'. Collegial relationships and friendships are important in forming real and functional social networks. Help may be needed with

mapping out personal interests and means of sharing those with others having similar interests, with social skills training, augmentative and alternative communication, time management, etc.

Individual, community, society – openness, attitudes

Besides supporting people with disabilities to gain (as far as possible) an independent life in inclusion; society at large, and local communities also need to be educated in attitudes towards people with disabilities - their values, rights, needs, and desires, in order to ensure a fulfilling life for all in the community. Support and advocacy services are necessary to make sure that the voices of people with disabilities are being heard and that a discussion can begin, shared experiences can take place. Local government agencies, related professionals and civil volunteers have to be informed and trained; and adolescents (in schools) have to be educated about human diversity and equity. All levels of society should understand and accept that there is no reason whatsoever to exclude citizens with disabilities from the stages of everyday life and that support services have to be directed towards assistance in inclusive lives in natural, typical environments within communities.

Residential services, supported housing schemes, mobile support staff

In the light of the normalisation principle, the goal is to provide support to persons with disabilities so that they can live and work in communities and surroundings most typical for normally developing peers. Large residential institutions are being replaced by community based supported housing schemes or assisted independent living. The desires and functioning levels of individuals have to be considered when choosing residential solutions and matching support services. If possible, support staff should visit supported housing schemes on a regular but temporary basis, and services should travel to clients locally, to their natural environments, instead of the clients needing to travel to service provision centres. Trained mobile support staff should provide services and a service/information-network between clients, professionals, and agencies.

IV. Contact management with institutions

Mapping of an institution's image

Many local projects emerge from the work of directly interested experts and/or clients (and their advocates), from direct needs and desires. A management professional is needed to coordinate such initial goals with potential governmental, statutory, human, financial and other resources so that an ideal team and service provision unit can be formed and more finely shaped, realistic goals can be set.

Professional relationship with clients

Clients become aware of the services either through advertising, in which case clients refer themselves; or they are referred to a service provision agency by a third party, based on specific needs or assessment results. The "home agency" or service coordinator of a client supervises the optimal condition of the client, regarding medical, mental health, and progress states in actual therapeutic and/or other supportive interventions that are provided. It is important to ensure that clients receive and can easily access (preferably in natural environments, and locally) all necessary

support; and, that the everyday functioning and well-being of the family unit is be monitored as well. After termination of particular interventions and services, clients and case studies should be followed-up, and appropriate information should be provided to other agencies and service providers currently responsible for the client - keeping confidentiality and legal issues in mind.

Cooperation network with several institutions

For optimal and seamless service provision, service providers have to build information networks so that they have readily accessible resources for areas outside of their specific competence. Cooperation with other institutions or agencies can occur on a case-by-case, or on a regular, mutual partnership basis. It is important to appoint one case coordinator or one "home agency" for a given client, which plays a supervisory and coordinative role, and also carries the primary responsibility for service provision.

Changes and how to initiate them

Employees may react differently to substantial changes in the working model of a team/institution. For an effective work force, it is necessary that the team members know and accept the philosophy and mechanics of the changing model. Attitudes need to be assessed and an objective picture of the functioning potential of a new model has to be drawn. Thorough training of employees is necessary. In cases; however, when smooth functioning cannot be obtained, research supports that work units will function better if non-compliant or non-competent team members are replaced by an ideal work force and those replaced are redirected to more suitable tasks for optimal work potential and team efficacy.

Putting theory into practice

Institutions may need counselling on a general management level, with access to information, training, or mapping out resources etc.; and also for individual case management for specific clients. Research suggests that a so-called gap from theory to practice exists. It is not sufficient to inform institutions and staff about theories and attitudes of service provision, but they have to be counselled and trained in the relevant techniques. Follow-up checks on the quality of new service elements and ongoing support and counselling have to be made to ensure that practices stay in effect.

2.3. Conclusion

The discussed content areas are contemplative and only give general guidance - they need to be elaborated in more detail, according to specific interests and foci in each training group and situation. Please refer to the professional literature for specific information, and for local regulations and exceptions.

3. Teaching methods

Lectures, demonstrations, explanations, discussions, literature reviews,

Visits to institutions, organised practical experiences (as needed; depending on the existing personal background experience of the participants)

4. Teaching material

Research literature

Guided notes

Video presentations

Technical media

MODULE IV

MANAGING DAILY SUPPORT

1. Learning objectives

- Basic principles/vocabulary of coaching/leadership roles
- Mechanics of teamwork and emerging leadership
- Processes and formal types of decision-making and problem-solving
- Goal setting and progress evaluation
- Human resources management
- Optimal parameters of support services in the field
- Administrative requirements of social services
- Services in the social and health care systems and their structures
- Systems of financial support / diverse resources in the field
- Project management techniques
- Mechanics of institutional- and personal support/coaching

2. Learning contents

2.1. Introduction

This training unit discusses the following three main topics:

- I. Leadership studies
- II. Support service management
- III. Supporting institutions

2.2. Main Part

I. Leadership studies

Mechanisms of evolving leadership, group mechanics

Working in a group may add to the potential and individual skills of the individual members; but additional organisational issues also need to be addressed. Team forming takes time, and group

norms will develop over time with possible conflicts till a team is ready to act together as a functional unit. In a group/team work situation, there are three basic influences that act between group members: conformity, obedience, and leadership. These roles may change in any given activity - but there is also a need for formal roles in team work. Optimal leadership qualities depend on each situation and mission. Ideally, the best leader within a context emerges from a mission - the leader's adequate qualities have to be recognised by the group members. If formally appointed, the group members have to accept the leader and follow his/her directions. Some issues of team formation and of leadership styles and qualities will be discussed later.

Cooperative skills (specific aspects of contact with the different sectors of health care, education, financial supervisors, and with other institutions)

A leader does not only have to be able to organise and control his/her team members but he/she also needs to be able to cooperate with leaders and organisers of different organisations for optimal project outcomes and seamless service provision to clients. The leader has to be able to objectively evaluate his/her team's effectiveness and limitations, and he/she has to accept cooperative work circumstances with the most competent experts - they have to be found, contacted and coordinated across teams and institutions.

Connections to local government offices

In the official service provision systems of countries, government agencies and offices have to ensure the functioning (and financing) of services. Service provision itself can be undertaken by non-governmental agencies as well (civil or church organisations), in which case these agencies need to cooperate with local government offices as their supervisors. Inversely, non-governmental agencies may have valuable information concerning actual service needs and circumstances which can lead to modifications of the state service system.

Supporting an institution: mapping of needs and resources, goal setting

Many local projects emerge from the work of directly interested experts and/or clients (and their advocates), from direct needs and desires. A management professional is needed to coordinate such initial goals with potential governmental, statutory, human, financial and other resources so that an ideal team and service provision unit can be formed and more finely shaped, realistic goals can be set. Such coordinating management work may also be required within already functional institutions for certain projects that involve new (less experienced) staff, directions or service provision models.

II. Support service management

Management skills training, supporting decision-making

A leader/manager needs to be highly competent within the actual field of the projects he/she is supervising and organising. In addition, he/she needs to have skills in coordinating, staffing / human resources management, mapping out additional (extraneous) information and resources, and in motivating his/her team to work towards these goals in accordance with project and institutional

philosophies and objectives. Good communication skills are also relevant. Leaders need to be able to influence their group and move them towards team decisions if a discussion seems to be stuck, "leading nowhere"; and, when the decision has been made by the leader only, he/she has to take responsibility for the consequences for employees who simply follow directions, without the competence/authorisation to deviate from them.

Establishing client contact

Clients become aware of services either through advertising, in which case clients refer themselves; or they are referred to a service provision agency by a third party, based on specific needs or assessment results. The "home agency" or service coordinator of a client supervises the optimal condition of the client, regarding medical, mental health, and progress states in actual therapeutic and/or other supportive interventions that are provided. It is important to ensure that clients receive and can easily access (preferably in natural environments, and locally) all necessary support; and, that the everyday functioning and well-being of the family unit is monitored as well. After termination of particular interventions and services, clients and case studies should be followed-up, and appropriate information should be provided to other agencies and service providers currently responsible for the client - keeping confidentiality and legal issues in mind.

Managing changes

Employees may react differently to substantial changes in the working model of a team/institution. For an effective work force, it is necessary that the team members know and accept the philosophy and mechanics of the changing model. Attitudes need to be assessed and an objective picture of the functioning potential of a new model has to be drawn. Thorough training of employees is necessary. In cases; however, when smooth functioning cannot be obtained, research supports that work units will function better if non-compliant or non-competent team members are replaced by an ideal work force and those replaced are redirected to more suitable tasks for optimal work potential and team efficacy.

III. Supporting institutions

Leadership and cooperative organisation skills

Institutions may need support, counselling or training in management skills, leadership efficacy and styles, cooperative and organisational skills - both for emerging leaders and for team members in order to ensure maximal and optimal performance levels. Sometimes, third-party involvement is necessary to resolve conflicts or to offer supervision and evaluation. It is crucial that a team is able to keep working together smoothly and with high individual (professional) involvement and motivation. Leaders need to be open, flexible, objective, fair, and committed to ongoing self-development. The leader has to ensure high-quality team work, but he/she is also responsible for providing professional

and mental health support and appropriate professional- and self-developmental venues for team members.

Building a team

Teaming is the process by which individuals, professionals and caregivers, work together to provide assessment and/or intervention services for a child and his/her family. Teams may progress forward and backward through specific stages. Teams may be characterised by more than one stage at any particular time. Common classification of stages - Stage I: Forming (Members are figuring out if they want to be on the team / Highly directive style is preferred in this stage). Stage II: Storming (Team members tend to focus on differences rather than similarities / The leader is blamed for the discord in the group; Conflicts must be resolved in this stage, or they are sure to resurface later). Stage III: Norming (Team focuses on similarities rather than differences / Conversations beyond work-place issues are common place; Basic logistics of group functioning have been established). Stage IV: Performing (Members are performing their responsibilities and doing their jobs well / Team is successful at resolving conflict when it arises).

Decision-making and group dynamics

In a well functioning team, all members need to feel free to bring in ideas and to get involved in planning, conflict resolution and decision-making. Some projects may require general participation and input - some other situations may make it necessary that the group leader decides in certain questions. Levin has pioneered the research on group dynamics and on how a team is functionally more than just a sum of its members. Levin has also studied the pitfalls and dangers of misleading discussions, as well as ways of resolution. (Please refer to the professional literature for desired information in detail.)

Building an information network, cooperating with other institutions/agencies

For optimal and seamless service provision, service providers have to form information networks so that they have readily accessible resources for areas outside of their specific competence. Cooperation with other institutions or agencies can occur on a case-by-case, or on a regular, mutual partnership basis. It is important to appoint one case coordinator or one "home agency" for a given client, which plays a supervisory and coordinative role, and also carries primary responsibility for service provision.

Case studies: assessment, evaluation, management of clients' problems

The assessment of clients' needs, desires, current functioning levels and progress has to be objectively attained at the onset of interventions (to obtain a baseline), and also frequently during the interventions to ensure optimal progress and necessary programme adjustments. Besides professional points of view, the client's and his/her family's own priorities and support have to be considered for optimal outcomes, so that service providers can count on cooperation based on the so-called social validity of the planned provided services. Services can be terminated if concrete goals have been reached, if no more progress is likely to occur within a reasonable cost-benefit ratio, or if the client

does not wish to participate any longer. Goal and/or methodological modifications have to be discussed with the client and/or the family/legal guardians.

Organisation of cultural, recreational and leisure activities (responsibilities and liability issues)

Some provided services do not aim for defined skill development, but for social and mental well-being. Cultural, recreational and leisure activities also play an important role in socialisation and social inclusion. Participation should be regular but voluntary, according to personal interests. A case manager has to map out interests and priorities, find possible ways of realisation, support necessary adaptations for full or at least partial participation. Transportation, peer-training (in attitudes and/or assistance) and safety issues also lie within the manager's responsibilities.

Counselling on the institutional and personal level – possible conflicts of external support vs. self-determination

Institutions may need counselling on a general management level, concerning access to information, training, or mapping out resources etc.; and also in individual case management for specific clients. Clients may request counselling on a personal level as well, with issues not within the primary interests of their agencies, or with confidential issues where they wish to seek out a neutral opinion. In certain cases, there may be a conflict between the personal wishes of the client and the professional suggestions of service providers. If discussions concerning the client's best interests and reality do not seem to resolve a conflict, a third, neutral party of counselling should be involved, accepted and agreed on by both conflicting sides. Local or institutional regulations may also apply and have to be considered.

Supporting/coaching employees of institutions

For counselling employees of institutions, a manager has to inform employees about changes in legal or local regulations and about new or newly available methodological-professional information and training opportunities. Supervision and private and/or workload-case counselling should be provided as well. Continuing (self-)education should be encouraged, and professional fitness should be supervised. This includes ongoing quality control of services provided by individual employees and/or teams. It is also important that employees' interests be represented in front of their leaders, making sure that employees can work under appropriate material, psychological, communicational, and financial circumstances.

Confidentiality issues

For ethical professional conduct, confidentiality has to be ensured both on the level of handling personal data and information about clients (please refer to your local regulations, especially regarding information availability within cooperative service provision across institutions/agencies!); and on the level of super- and subordinated employees and their relationships. Formal regulations may exist concerning appropriate personal interactions within professional relationships and for

appropriate evaluation and critique. Prejudice and discrimination, biased decision-making have to be fought against at all levels.

2.3. Conclusion

The discussed content areas are contemplative and only give general guidance - they need to be elaborated in more detail, according to specific interests and foci in each training group and situation. Please refer to the professional literature for specific information, and for local regulations and exceptions.

3. Teaching methods

Lectures, demonstrations, explanations, discussions, literature reviews,
Visits to institutions, organised practical experience (as needed; depending on the existing personal background experience of the participants)

4. Teaching material

Research literature

Guided notes

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Technical media

MODULE V

NEW MEDIA IN DAILY CARE

1. Learning objectives

The use of new media in daily care offers a variety of possibilities; however, there is a lack of knowledge and advisers in this sector. One major reason for this is the rapid progress in the ICT developments which enables the use of new media in fields never before contemplated. However, adequate qualifications are required. To date there are no customised training materials available to train coaches in the usage of new media for people with disabilities

On completing this module the coaches should be aware of the possibilities of the use of new media in daily care; and furthermore, they should be able to acquire the necessary information concerning the implementation of such applications. Finally, the coach will be able to advise managers and personal assistants about the use of new media as a sensible instrument in daily work. To achieve this he/she should achieve competence in the use of new media in daily care. The institution coach should also be able to advise managers and carers concerning infrastructure, supply, ownership and cost of new media.

2. Learning contents

2.1 Introduction

The rapidly developing information and telecommunication technology presents opportunities as well as dangers to people with disabilities (Busse and Hamburg 2006). These dangers are for example the "digital divide" between people with and without disabilities that can lead to a further exclusion of people with disabilities from society, "substitution" of personal care with technical items and badly designed infrastructure and devices. The following areas for the use of new media and technology for people with disabilities in institutions and at home will be presented (Collacot et al. 1992):

- Communication and information services and devices – telecommunication
- Daily living - telecare
- Telemedicine
- New media to train personal assistants and people with disabilities

- The use of new media for public relations and lobbying

Apart from the areas of new media for people with disabilities two important preconditions for the use of new media will be presented:

- Media competence
- Infrastructure and costs for using new media in daily care

2.2 Areas of new media in the care for people with disabilities

2.2.1 Communication and information services and devices - telecommunication

Telecommunication is the transmission of signals over a distance for the purpose of communication. In former times telecommunication took place via drums, smoke signals or semaphores but today the term is closely connected with the transmission of electromagnetic waves i.e. the usage of television, radio, telephone or computer networks. Specially designed and easy to use information and communication services can help people with disabilities to integrate into society and allow to partly compensate the disadvantages of the disabilities. Some examples are the following:

For someone with a very severe hearing impairment, or profound deafness who cannot benefit from amplification, the only solution is a text telephone. People with speech and motor impairments often communicate slowly. Electronic mail and computer conference could give them new channels of social interaction; and, to some degree a compensation for their lack of opportunities for face-to-face communication. Limited speed of communication is not a disability in this mode.

The developing technology of speech relay and speech synthesis offers exciting prospects, not only in providing a voice for those with speech difficulties, but in helping blind customers to use telecommunications and other equipment.

Other applications are:

- o Picture communication and video telephony can be used for people who cannot read well or who cannot understand written instructions for operating the telephone
- o Different computer games or video games are very useful to gain an understanding of some notions and computer skills,
- o A smarter home information system can help inhabitants to remember dates, times, family members.

2.2.2 Daily living - telecare

Telecare is a means of remote care by using detectors, monitors (for example, motion or fall detectors or blood pressure monitors) or emergency communication devices which allow people who are in need of special supervision and care (e.g. people who are at risk of falling or people with dementia) to remain in their own homes (Mansell 1993;Kurtz 2001). These communication and supervision devices are often linked to community alarm systems that trigger a warning at a control centre that can be responded to within a defined times (Eustis and Fischer1992).

Some telecare aids which offer; on the one hand, more autonomy for the person with disabilities; and, on the other hand, less pressure on the staff, will be presented:

- Set off local alarm (e.g. siren, flashing light)
- Turn off a cooker or turn on a table lamp during the night
- Shut off a gas supply or provide an alert for flooding
- Send a message to a control centre as an alert
- Maintain an open line to a control centre for the user to make contact in an emergency
- Request a visit from response or backup services e.g. nurse, ambulance services
- The smarter home information system can alert people with disabilities in daily routines like taking medicines, eating, etc
- Reporting unusual behaviour or movement patterns; such as, not leaving a room for a long period

Telecare equipment should be used as an additional tool in a package of care and support or as an option to extend independence. It should not replace care but supplement it. It is important that telecare is embedded in an overall care strategy for a person with disabilities.

Telecare offers the possibility to identify changes in the personal circumstances of the user in an objective way and allows for privacy in a more flexible way than personal care. The technologies used by telecare can also be used for total surveillance of a patient therefore abuse of surveillance devices and records must be prevented.

A major advantage of telecare is to provide objective data about the user's real levels of activity, vital signs and circumstances within the normal environment of his/her own home and daily living. One precondition for the successful use of the tele-services is that they are easy to use according to the users (dis)abilities.

The cost/benefit calculation of telecare is not easy to work out but it can be assumed that telecare used under the right conditions generates a win-win situation for society and the client. The following things must be taken into account before applying telecare:

- Telecare can help to prevent the need for a client to be cared for in a home (cost saving and increasing quality of life) but the measures for the client must be necessary and affordable.
- The technical solutions which are used must be suitable, available, secure and affordable. The use of expensive "high-tech toys" without added value is a risk that must be taken into account.
- It is obligatory to secure a sufficient amount of personal care.
- Privacy and data protection must be granted

The costs for the technical aids ranges from almost free, like a special fast dialling mobile phone number, to a great sum for a "smart house".

2.2.3 Telemedicine is a new branch in medical treatment and diagnosis. Telemedicine generally refers to the use of communication and information technologies for clinical care. It includes consultations between physicians via telecommunication as well as long-distant treatment or the diagnosis of patients by using technical aids.

Attributes of telemedicine are:

- the spatial and/or temporal separation between the treating or consulting person; and,
- the treated or consulted person.

The technical-based aids range from a telephone call to robotic surgery.

Some steps of the long-distant care and consultation are:

- Communication via post (previously)
- Long-distant care by means of telephone and (especially in sparsely populated areas) by two-way radio
- The use of new ICT (WWW, computers, video conferences) and the development of diagnosis/treatment devices which allow for a special/temporal separation between physician and patient (e.g. robots, recording devices).

Some applications of telemedicine are:

- Teleconsultation and remote diagnosis when a difficult problem appears and the expert is not present
- Video telephony for supervision, to help a non-trained person cope with some medical treatment problems, etc.

2.2.4 Using new media to train personal assistants and people with disabilities

The term "new media" refers to any interactive media, esp. electronic mass media combined with computers.

Training based on new media particularly when the training material is found on the Internet (Web-based Training- WbT) has the potential to offer many advantages over traditional instructor-led training for learning, providing flexibility in terms of time, place, adaptation of the learning material, audience, and individualised (customised) content (Flanagan 1997; Kraus et al. 1999).

In theory distance education particularly by using new media is ideally suited for people who are not able to attend traditional environments due to their disabilities, but unfortunately such training courses are not always accessible to all learners who wish to participate. When designing distant education, the ability (disability) and interests of the learner as well as the structure of the learner's computer hardware and software have to be considered.

Firstly, the accessibility should be understood by course developers and in a second step the instructional design needs to be carefully applied. Considering that accessible training courses can be created that benefit all learners.

Initially, course developers should take easy steps to improve accessibility. More difficult and specialised techniques for a particular type of disability require compromises: for example when attending the needs of a special disability the content could become less accessible to people with other disabilities. In order to maximise accessibility, established guidelines should be followed and an appropriate balance between the needs of the users should be determined.

It is also important to understand difficulties a person with disabilities has with accessibility due to the software/hardware they are using caused by differences in browsing programmes.

In connection with the improvement of accessibility through website design it needs to be mentioned that there are many organisations which promote good design for example the Web Accessibility Initiative (WAI) a division of the World Wide Web Consortium (W3C).

While developing distance courses with new media services for learners, it is necessary to pay attention to employ media appropriate to the target group and to bridge geographical distance. Organisational forms can provide adequate support (technical, social etc.), to make sure that the learners have adequate IT-skills (Hamburg and Busse 2006)

Some methods offered by training using new media that can be used both by personal assistants as well as people with disabilities are the following:

- Personal training where the learners work alone in small groups having access to different technical and pedagogical means well-adapted to their training fields (e.g. literacy, learning communication, etc) such as video and audio tapes, special software, e-mail for communication with teachers.
- Distance training where the trainer is located at a transmission place and follows the learner's work by the Internet in real time. Phone conversations, audio and video conferencing allow

the trainer to contact the trainees. Interactive software makes the training processes more attractive if the trainees are able to use it.

- Physical presence combined with the use of new media.
- Blended learning e.g. a combination of distance electronic learning and classroom learning with direct contact with individuals in groups.

One example of a prototype for a multimedia training system to meet the learning needs of people with disabilities in sheltered workshops has been developed by the MULTIPLE project which uses the Detmold Learning Path Model.

For Information about the integration of people with disabilities into information society and the use of electronic learning for trainees with disabilities and trainers, the website of the European Disabilities Forum (EDF) (<http://www.edf-feph.org/>) can be visited. This website also contains web-links to national organisations for the disabled which can provide additional information about ICT-usage for the disabled as well as for trainers or personal assistants.

2.2.5 The use of new media for public relations and lobbying

It is important for any interest group to have a "voice", i.e. expressing the group's needs and desires in such a way that the decision makers or public opinion are influenced. To reach a large number of people with a small monetary input the usage of new media should be considered. In social services public relations and lobbying are imperative. On the one hand, the staff have to fight against prejudices and fears ("people with intellectual disabilities are violent"), on the other hand, they have to fight against cuts in budget. The use of technology to provide proper information to the public and special target groups will be demonstrated.

2.3 Conclusions

The use of new media in daily care will become increasingly important in all developed countries. The required ICT infrastructure will be inevitably built up by the general spread of ICT. However some points must be taken into account:

- There is no doubt that the efficient development/use of new media in daily care requires fundamental knowledge and skills. The coach should understand that "media competence" is more than being able to use a computer. It is principally a communicative skill and so it is a bundle made up of basic knowledge, structural knowledge, orientation knowledge and application knowledge. In addition this knowledge has to contain a social and ethical element.

- Before one can take advantage of new media, the management of the institution will need to ensure that the relevant infrastructure is created, such as: staff training and development, the supply and management of equipment, the supply of technical assistance.
- The fact that people with disabilities are often less interested in new, unfamiliar gadgets compared to what they are used to, needs to be considered. It is important that the user interfaces do not disturb their current way of living and that they integrate seamlessly into the home environment allowing instant use of the services without major training requirements.
- For the supply and ownership of new media equipment different options exist: direct purchase and ownership, leasing, rent/managed service
- As well as opportunities there are also risks in the use of new media in daily care. If the impact of new media is not correctly managed discrimination and isolation of those that are not able to adapt to new technologies can be increased. On the other hand, the digital divide, the gap between those with regular, effective access to digital technologies and those without, can grow.
- The application of technology causes more complexity and complexity causes vulnerability. It is important to take care of such problems like energy shortages (e.g. electrical energy) or system failures by generating systems equipped with a backup mechanism.

3. Teaching methods

To teach the contents "blended learning" will be used, e.g. a combination of distance electronic learning and classroom learning with face-to-face contact in group training. Beside the traditional advantages of electronic learning (e.g. more flexibility, personalised learning, more staff can be trained, the lack of adequate trainers can be avoided) the advantages of new media can be demonstrated by using simulations and video animation. Additionally, all electronic teaching materials should also be delivered as paper documents.

4. Teaching material

The teaching material will be prepared in multimedia form. Animations will be integrated in order to demonstrate some applications of new media. Self-test exercises for each part will be included.

The trainees will receive a CD-ROM with the multimedia form of the teaching material and they can load and print the texts from the project platform.

Power Point presentations with a short presentation of the applications will be used during the blended learning sessions.

ANNEX I

SPECIFIC LITERATURE

MODULE I

Association of Parents Guardians and Friends of People with Disabilities HERMES (2005) *Development of Educational Material for the Training in Accompanying Support Services* for the National Accreditation Centre for Continuing Vocational Training (EKEPIS) - GREECE

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