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CITY OF ASHEVILLE

AMERICANS WITH DISABILITIES ACT SENSITIVITY TRAINING

MAY 1995

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TO

THE

AMERICANS

WITH

DISABILITIES

ACT (ADA)

THE AMERICANS WITH DISABILITIES ACT OF 1990

AN OVERVIEW

I. INTRODUCTION

The Americans with Disabilities Act of 1990 (ADA) was signed into public law (101-336) on July 26, 1990. It is a sweeping civil rights law that is intended to eliminate discrimination against people with disabilities in all aspects of American life. This law includes provisions regarding employment, state and local government services, public transit services, public accommodations, and communications.

In other words, this law gives civil right protections similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. City of Asheville, as a public provider of leisure services, is subject to compliance with this law.

II. TITLE I - EMPLOYMENT

EFFECTIVE DATE : July 26, 1992 - 25 or more employees
***July 26, 1994 - 15 or more employees**

Any employer is prohibited from discrimination on the basis of disability in any employment action. Employers should develop a job analysis to determine the essential functions of each job. When an individual with a disability meets legitimate educational, skill, and experience qualifications for a position, and can perform the essential functions of a job, the employer must make a *reasonable accommodation.* Reasonable accommodations include, but are not limited to, reassignment of non-essential tasks, providing auxiliary aids or services, removing architectural barriers in the work place, changing the individual's work schedule, permitting supplemental unpaid leave, or reassignment of an employee to a vacant position.

II. TITLE II - PUBLIC SERVICES
STATE AND LOCAL GOVERNMENT SERVICES - SUBTITLE A

EFFECTIVE DATE : January 26, 1992

State and local governments shall not exclude an individual with a disability, from participation in, or the benefits of, programs, services, and activities, who with or without a reasonable accommodation, meet *essential eligibility* requirements. Units of local government must conduct self-analysis to identify discriminatory practices and barriers, and shall remove all structural barriers within three years of January 26, 1992 or as expeditiously as is possible.

III. TITLE II - PUBLIC SERVICES
PUBLIC TRANSIT - SUBTITLE B

EFFECTIVE DATE : August 26, 1992

State and local governments which provide public transit systems must assure that all services are readily accessible to and usable by individuals with disabilities. Public transit systems include fixed route systems, demand responsive systems, para-transit systems, and rapid rail systems. Certain requirements are phased in over a period of time because of anticipated difficulty in funding for massive structural changes.

IV. TITLE III - PUBLIC ACCOMMODATIONS AND SERVICES OPERATED BY PRIVATE ENTITIES

EFFECTIVE DATE : January 26, 1992

All private, non-profit, and general businesses which provide goods, services. or facilities for the public is prohibited from discrimination on the basis of disability in the provision of those services. Entities must provide reasonable accommodations for those individuals with disabilities. Where removal of a barrier will require structural change, removal must be *readily achievable.* If not , *alternative methods* of accommodation must be considered.

V. TITLE IV - TELECOMMUNICATIONS

EFFECTIVE DATES: July 26, 1993

Telephone companies must provide telephone systems and other communication services that are available to people with hearing impairments and people with speech impairments all day, every day.

VI. TITLE V - MISCELLANEOUS PROVISIONS

In general, this title depicts the ADA' s relationship to other laws, explains insurance issues, prohibits state immunity, provides congressional inclusion, sets regulations by the Architectural and Transportation Barriers Compliance Board (ATBCB), explains implementation of each title, notes amendments to the Rehabilitation Act of 1973, and gives alternative means for dispute resolutions.

GLOSSARY TERMS
FOR AMERICANS WITH DISABILITIES ACT

03/16/95

1. **ADA** - Americans with Disabilities Act signed into law by President George Bush on July 26, 1990. See Overview for more details of this law.

2. **PUBLIC ENTITY** - as covered by title II is defined as:
   a). any State or local government;
   b). any department, agency, special purpose district, or other instrumentality of a State or local government; or
   c). certain commuter authorities as well as AMTRAK.

3. **DISABILITY** - an individual with a disability is a person who -
   a). has a *physical or mental impairment* that substantially limits one or more of the *major life activities*;
   b). has a *record* of such an impairment; or
   c). is *regarded as having* such an impairment.

4. **PHYSICAL OR MENTAL IMPAIRMENT** -
   A). Physical impairments include physiological disorders or conditions; cosmetic disfigurement; or anatomical loss. Specific examples of physical impairments include orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV disease (symptomatic or asymptomatic), tuberculosis, drug addictions, and alcoholism.
   B). Mental impairments include mental or psychological disorders, such as mental retardation, organic brain syndrome, emotional or mental illness,and specific learning disabilities.

5. **MAJOR LIFE ACTIVITIES** - include such activities as caring for one's self, performing manual tasks, walking, seeing, speaking, breathing, learning, and working.

6. **RECORD OF A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITED A MAJOR LIFE ACTIVITY** - this protected group includes:
   a). a person with a history of an impairment that substantially limited a major life activity by who has recovered from the impairment. Examples might be persons with histories of mental or emotional illness, drug addiction, alcoholism, heart disease, or cancer.
   b). a person who have been misclassified as having an impairment.

7. **REGARDED AS HAVING AN IMPAIRMENT** - protects certain persons who are regarded by a public entity as having a physical or mental impairment that limits a major life activity, whether or not that person actually has an impairment. Three typical areas are covered here:
   a). an individual who has a physical or mental impairment that does not substantially limit major life activities, but is treated as if it would;
   b). an individual who has a physical or mental impairment that substantially limit major life activities only as a result of the attitudes of others towards the impairment;
   c). an individual who has no impairments but who is treated by a public entity as having an impairment that substantially limits a major life activity.

8. **QUALIFIED INDIVIDUAL WITH A DISABILITY** - refers to an individual with a disability who, with or without *reasonable accommodations* to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the *essential eligibility requirements* for the receipt of services or the participation in programs or activities provided by a public entity.

9. **ESSENTIAL ELIGIBILITY REQUIREMENTS** - will depend on the type of service or activity involved. The minimum criteria for essential eligibility is likely to include: capacity, charges, and conduct required. There are four additional factors which may modify essential eligibility: residency, relative skill, safety, and age. For some activities, such as State licensing programs, the ability to meet specific skill and performance requirements may be "essential".

10. **REASONABLE ACCOMMODATIONS** - are those accommodations made for a person with a disability who could meet the essential eligibility requirements for a program. It is the responsibility of the departments to make these reasonable accommodations for people with disabilities when assistance is needed because of the disability. Five types of reasonable accommodations were specifically named as follows:
    a). Change policies, practices, or procedures
    b). Remove transportation barriers
    c). Provide auxiliary aids or services
    d). Remove architectural barriers
    e). Remove communication barriers

11. **MOST INTEGRATED SETTING** - is one which enables interaction between people with and without disabilities to the maximum extent feasible. Integration of individuals with disabilities into the mainstream of society is fundamental to the purposes of the ADA. An essential obligation exists to provide equivalent opportunities, but does not oblige a parks and recreation department to guarantee successful participation. Public entities may not provide services or benefits to individuals with a disabilities through programs that are separate or different, unless the separate programs are necessary to ensure that the benefits and services are equally effective.

12. **UNDUE BURDEN** - is when an accommodation would result in a substantial economic or administrative burden, or result in a fundamental alteration of the nature of the service, an agency may refuse to make the accommodation. In any case, documentation must follow the decision.

13. **SUBSTANTIAL ECONOMIC BURDEN** - an analysis of the following factors might be considered in order to substantiate economic burden: total operating budget of the department; the budget of the division or unit where the accommodation is being considered; the cost of the accommodation; the number of individuals to benefit from the accommodation; the availability of the funds within the current operation of capital budget of the department.

14. **ADMINISTRATIVE BURDEN** - is very much like economic burden, but factor to consider might include: number of employees in the department; number assigned to the division where the accommodation is being considered; number of employees required to make the accommodation; whether the assignment of employees to make the accommodation will result in a failure in completion of other tasks.

15. **FUNDAMENTAL ALTERATION** - an understanding of the nature of the program, service, or activity where the accommodation will occur is essential. If an accommodation results in a fundamental alteration of the program, the department need not make the accommodation. Some questions to be considered might include asking does the accommodation:
    a). require "massive change" in the program
    b). endanger a program's viability
    c). "jeopardize the effectiveness" of the program
    d). require a "major restructuring" of a program, or
    e). require the creation of a new program

16. **ALTERNATIVES METHODS** - in this instance, refers to readily accessible non-structural means of program accessibility. These include:
    a). redesign of equipment;
    b). reassignment of services, programs, and activities to accessible buildings;
    c). assignment of aids to beneficiaries;
    d). home visits;
    e). delivery of services to alternative accessible sites;
    f). alteration of existing facilities or construction of new facilities;
    g). use of accessible "rolling stock" or other conveyances;
    h). or any other methods that result in making it services, programs, or activities readily accessible to and usable by individual with disabilities.

Sources:

McGovern, John The ADA Self Evaluation (1992) National Recreation and Park Association Resource Development Division

Codes of Federal Register Part 35-36, Public Law 101-336, ADA 1990

ASHEVILLE

Interoffice Memo

TO: Parks and Recreation Department Staff
FROM: Lyle Willis, City ADA Coordinator LW
RE: New Access Statement
DATE: March 20, 1995

Below is the new Access Statement, which has been reviewed by the legal department. It is the responsibility of all Parks and Recreation staff to see that this Access Statement is displayed on the inside front cover of any brochure, flyer, registration or other promotional information, including co-sponsored events. Appropriate access symbols are to be used where applicable. Also, this statement should be displayed in a standardized large font (at least 14 pt.). By incorporating this Access Statement, the City of Asheville is taking the first step to publicize its commitment and willingness to work on accessibility issues.

If you have any questions concerning this matter, contact Lyle Willis.

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1. Use the statement below for general information and on small brochures, per M. McGlohon:

SMALL STATEMENT

*The Parks and Recreation Department of the City of Asheville does not discriminate on the basis of race, sex, color, age, national origin, religion or disability in its employment opportunities, programs, services, or activities.

2. Use the statement below for flyers, brochures or pamphlets advertising a City of Asheville or Parks and Recreation Department event, or to advertise a public hearing, per M. McGlohon:

LARGE STATEMENT

*The Parks and Recreation Department of the City of Asheville does not discriminate on the basis of race, sex, color, age, national origin, religion or disability in its employment opportunities, programs, services, or activities. Auxiliary aids and services are available with advance notification. Please let us know how we can best meet your needs in accessing any of our facilities or programs. Contact us at the Asheville Parks and Recreation Department at 259-5800. The City of Asheville's TYY number is 259-5548.

*At the asterisk, insert the appropriate city department if this statement is used by other departments. In the Large Statement, add the appropriate phone number.

PARKS AND RECREATION
First Nationally Accredited Municipal Recreation Department
CITY OF ASHEVILLE
POST OFFICE BOX 7148
ASHEVILLE, NC 28802
(704) 259-5800

TEN DOs AND DON'Ts
WHEN YOU MEET A PERSON WITH A DISABILITY

1. Offer assistance as you would to anyone else, for example, to push a wheelchair or to guide a blind person. The person will indicate whether or not the help is needed, and a "No, thank you" must be respected. Most people with a disability will not hesitate to ask for needed help and will be specific as to how it should be given: for example, the blind person usually prefers to take your arm rather than to have you grab his/hers.

2. Noticing an obvious disability is not rude; however, asking personal questions about it is inappropriate.

3. Always talk directly to the person with the disability rather than to the person who may be accompanying him or her. Never talk about the person with the disability to the person he or she is with as if the person does not exist. This includes an interpreter for a deaf person.

4. Do not be concerned if you use the words walking or running when talking to a person in a wheelchair, or "Do you see?" when talking to a blind person. People with disabilities use these words themselves and think nothing of it.

5. Do not avoid using words like blind or deaf when associating with people with these disabilities. They know that they have these disabilities and do not need to be shielded from the facts.

6. When talking with a person in a wheelchair for any length of time, it is better to sit down in order to be at the same eye level. It is very tiring for a person to look up for a long time.

7. Be sensitive to architectural barriers in your facility. Be aware of federal and state laws that may apply to eliminating architectural barriers in your establishment. Everyone must be concerned and alert to this very real problem.

8. Remember that if a person does not turn around in response to a call, it may be that he or she is deaf. A light tap on the shoulder to get a person's attention would be appropriate.

9. Never gesture about a blind person to someone else who may be present. This will inevitably be picked up and make the person who is blind feel that you are "talking behind his or her back".

10. Lip reading by deaf persons can be aided by being sure that the light is on your face and not behind you and by taking all obstructions such as pipes, cigarettes or gum out of the mouth, keeping the lips flexible, and speaking slowly. Additional communication could include body language, pantomime and gestures of all kinds, and written communication if necessary.

The NEW Facts About Disability

General Information

- There are 48.9 million Americans with a disability. This represents 19.4% of the total population of the United States. In other words, nearly 1 in 5 Americans has some type of disability.

- 24.1 million have a severe disability, which represents 9.6% of the total population.

Age

- There are 29.5 million Americans with disabilities who are between the work ages of 15 to 64.

- 13.2 million of these individuals have a severe disability.

- 2.9 million children have a disability, and 16.5 million adults 65 and older have a disability.

- The 65 and older group is the most severely disabled. Of the 16.5 million adults in this age range with a disability, 10.4 million have a severe disability.

Employment and Earnings

- For persons without a disability, the employment rate is 80.5%. For those with a severe functional limitation, however, the employment rate is only 27.6%.

- The mean earnings for people between the ages of 35 to 54 who have no disability is $2,446 per month. Those in the same age range with a non-severe disability have an average monthly earning of $2,006. For those with a severe disability, the average monthly wage is $1,562.

Functional Limitations of Persons 15 to 64

- The following were the most commonly cited functional limitations for persons between the ages of 15 and 64.

Climbing	8.1 million
Walking	7.9
Lifting	7.8
Hearing	5.5
Seeing	4.8
Speaking	1.5

Disabling Conditions of Persons 15 to 64

- Of the nearly 29.5 million persons between the ages of 15 to 64 who reported the cause of their disability, the following represent the most common causes:

Back or spinal problems	3.9 million
Arthritis or rheumatism	2.7
Heart problems	1.5
Lung or respiratory problems	1.4
Limb disorders	1.2
High blood pressure	1.0
Diabetes	0.8

Insurance Coverage of Persons 15-64

- Of the 29.5 million Americans with disabilities between the ages of 15 to 64, 18.4 million are covered by private insurance. Of the 11.1 million not covered by private insurance, 4.4 million are covered by Medicaid, and 5.1 million have no form of health insurance.

- For those with a severe disability (13.2 million), 6.3 million are covered by private insurance. Of the 6.8 million not covered by private insurance, 3.6 million are covered by Medicaid and 2.1 million have no health insurance.

Years of School Completed for Persons Between 25 and 64

- For the 26.0 million adults between the ages of 25 and 64 who have a disability, 7.8 million have not finished high school. Another 10.1 million have completed high school, but have had no college education. The remaining 8.1 million have had at least some college education.

- For the 12.0 million adults between the ages of 25 and 64 who have a severe disability, 5.0 million have not finished high school; 4.3 million have completed high school, but have had no college education; and 2.7 million have had at least some college education.

Source:

McNeil, J. M. (1993). Americans with Disabilities: 1991-92. U.S. Bureau of the Census Current Population Report P70-33. Washington, DC: U.S. Government Printing Office.

President's Committee on Employment
of People with Disabilities

TEN COMMANDMENTS OF ETIQUETTE FOR COMMUNICATING WITH PERSONS WITH DISABILITIES

1. When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter.

2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)

3. When meeting a person with a visual impairment, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.

4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.

5. Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others. (Never patronize people who use wheelchairs by patting them on the head or shoulder.)

6. Leaning or hanging on a person's wheelchair is similiar to leaning or hanging on a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.

7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod or shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue in and guide your understanding.

8. When speaking with a person in a wheelchair or a person who uses crutches, place yourself at eye level in front of the person to facilitate the conversation.

9. To get the attention of a person who is hearing impaired, tap the the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly and expressively to determine if the person can read your lips. Not all people with a hearing impairment can lip read. For those who do not lip read, be sensitive to their needs by placing yourself so that you face the light source and keep hands, cigarettes and food away from your mouth when speaking.

10. Relax. Don't be embarrassed if you happen to use accepted, common expressions such as "See you later." or "Did you hear about that?" that seem to relate to a person's disability.

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VARIOUS

DISABILITIES

Taking the HANDICAP out of DISABILITY

Introduction

In recent years, much attention has been given to the rights of people with disabilities. Legislation such as the Americans with Disabilities Act and efforts of many consumer groups have spurred ramp construction, affirmative action to increase employment opportunities and television programming to include realistic role portrayals for people with disabilities.

These developments - resulting from the recognition that people with disabilities are, indeed, valuable and equal members of society - have helped people with disabilities lead more productive lives.

However, many people still view individuals with disabilities as lesser people - to be pitied, feared or ignored. These attitudes may arise from fear of someone who is different in any way or simply from a lack of knowledge about disabilities. Despite good intentions and education programs, negative stereotypes and callous behavior remain.

This brochure gives suggestions on how to relate to people with disabilities, how to look beyond the disability and look at the ability and the personality - the things that make each of us unique and worthwhile.

Attitudes & barriers

A person with a disability is - first and foremost - a person. While a particular disability may limit certain types of activities or abilities, it does not make the individual any less a person. Ten to 15 percent of the population has a disability such as blindness, deafness, paralysis, cerebral palsy, neurological disorder, mental illness, arthritis or mental retardation.

An attitude is a feeling or emotion which a person has towards a fact, situation, or person. Awareness is the knowledge or perception about a situation, object or person. Attitudinal barriers are a way of thinking or feeling that blocks or limits people's perception of the potential of people with disabilities to be capable, independent individuals. Attitudinal barriers include prejudice, ignorance, fear, insensitivity, bigotry, stereotyping, misconception, discrimination, dislike, insecurity, discomfort, tension and intolerance.

Positive attitudes and awareness help people in their contacts and relationships with people with disabilities. Attitudes which are insensitive and prejudical produce poor relationships. A person may not be aware of biases or negative attitudes and may express them in words or actions.

Communication: the two-way street

If you are not used to communicating with a person with a disability and have any hesitations or concerns, here are a few tips:

USE COMMON SENSE -- People with disabilities want to be treated the same way as everyone else.

BE POLITE -- Show the person the same respect that you would expect to be given to you.

BE CONSIDERATE -- Be patient, take time and try to understand the problem or need of the individual.

OFFER ASSISTANCE -- Do not hesitate to offer assistance. However, do not automatically give help unless the person clearly needs help or asks for it. If the person declines your offer, do not insist on helping. Ask the person if assistance is needed and how it should be given.

COMMUNICATE -- Talk directly to the person. It is not difficult to communicate with a person with a disability. In some cases, it may take a little time, depending on the person's disability.

EMERGENCY ACTION -- Know the location of people with disabilities in your building to help with evacuation, if necessary, during an emergency.

Helpful Hints

While the following list is not inclusive of all disabilities, it does give some tips to use when meeting people with some common disabilities. Each persons particular disability may vary in how it affects them compared to how it affects another person. Sometimes a person may have more than one disability. While the following hints may be useful when applied in general, each person is affected by a disability in an individual way.

Hearing Impairments

A person's failure to respond to a spoken request or warning may be the result of an inability to hear. Gestures and gutteral sounds made by a person with deafness and or hearing impairments are not signs of anger, belligerance or intoxication. They may be the individual's only method of communication. However, many individuals with hearing impairments have very clear speech.

When communicating with a person with a hearing impairment:

* Be considerate and try to make the person feel comfortable and confident in dealing with you.
* Look directly at the person to whom you are speaking. Speak slowly - the person may wish to lip read. If a sign language interpreter is present, talk directly to the person with deafness - not the interpreter.
* Be flexible with your language. If a word is not understood, try another word rather than simply repeating yourself.
* Be aware of false interpretations (a nod of the head does not necessarily mean "I understand").
* Do not shout. Hearing aids make sounds louder, not clearer.
* Use of sign language, miming, gesturing, etc., is encouraged in augmenting lip reading abilities. Even minimal sign language skills can make lip reading easier.
* If all else fails, use a pad and pencil to communicate.

Blindness or visual impairments

People with blindness or visual impairments rely on their other senses to perceive the world around them. When you are with a person with blindness or a visual impairment:

* Speak directly to the person, using a normal tone of voice. Blindness does not affect a person's hearing.
* Do not be afraid to use terms such as " See you soon." Everyday words relating to vision are used by people with blindness themselves.
* Offer assistance but be guided by the individual's response.
* Be specific in giving directions. It is useless to point or give visual landmarks. If the individual must make a turn, state whether it should be left or right.
* Walk alongside and slightly ahead of a person with blindness or a visual impairment when you are assisting.
* Never hold the person's arm while walking. Let him or her hold your arm. The motion of your body tells the person what to expect.
* Avoid escalators or revolving doors, if possible. These can be disconcerting and dangerous.
* Assist the individual on stairs by guiding a hand to a banister. If there is no banister tell them whether you are going up or down and when you are at the end of the staircase or at a landing.
* When giving assistance in seating, place the person's hand on the back or arm of the seat.
* Never leave a person with blindness in an open area. Instead, lead the person to the side of a room, to a chair or some landmark from which you or another person can provide them a direction for travel.
* Do not leave a person with blindness abruptly after talking, without saying that you are leaving. Otherwise, he or she may try to continue the conversation with you when no one is listening or present.
* Do not pet a guide dog. The dog has an important job to do and petting may be distracting.

Mental retardation

People with mental retardation have limited ability to learn and sometimes have difficulty in using what they have learned. Through education and training, however, many people with mental retardation can learn to be self-sufficient. When communicating:

* Do not use complex sentences.
* Make instructions clear and concise.
* Do not be condenscending. Talk to the person as a person: talk to adults as adults, not as children. Each person deserves the same respect as anyone else.

Individuals use wheelchairs, crutches, or leg braces as a result of a variety of disabilities including spinal cord injury, multiple sclerosis, muscular dystrophy, arthritis, cerebral palsy or polio. Wheelchairs provide mobility for persons with paralysis, muscle weakness, lack of coordination, nerve damage and stiffness of joints. When you are with a person using a wheelchair:

* Talk directly to the person using the wheelchair, rather than to someone else. People using wheelchairs are fully capable of speaking for themselves.
* Push a wheelchair only after asking the person if assistance is needed.
* When assisting someone using a wheelchair to go up or down a curb, ask if the person perfers to go forward or backward.
* In guiding a wheelchair down an incline, hold the push handles so that the chair does not go too fast.
* Learn the location of wheelchair-accessible ramps, restrooms, elevators and telephones.
* For more than one step, keep the chair tilted back at all times while descending or ascending.

Cerebral Palsy

Cerebral palsy is not a disease but a condition that affects the muscles and, in some cases, the senses. The effects of cerebral palsy vary from mild to severe, depending on which part of the brain is affected. In some instances, the condition is barely noticable, while in others, the person may be unable to speak, may not have use of hands or may be unable to walk. When with a person with cerebral palsy:

* Be yourself.
* Speak directly to the individual, not to a friend or companion.
* Try to give your whole, unhurried attention if the person has difficulty speaking.
* Do not complete the speaker's sentences. Let the person finish.
* Do not be afraid to ask the person to repeat something.

Mental illness

People with mental illness are people whose emotional or mental abilities to cope with life are impaired, usually only for a short time. Mental illness is not the same as mental retardation. Most people recover from a mental illness just as most people recover from a physical illness or disease. Usually, you will not know that a person ever had a mental illness. However, if you come in contact with someone who is having a mental or emotional crisis:

* Ask if anything is the matter and offer to talk.
* Offer to get the help of a friend, relative or clergy.
* Offer to obtain the services of a psyciatrist, psychologist or trained counselor.
* Do not call the police or an ambulance unless there is a clear indication that the person is potentially harmful to others or to him/herself.

Epilepsy

Epilepsy is a hidden disability and is a disorder of the nervous system. Seizures are a primary characteristic of epilepsy, but they can be controlled or prevented by the use of medication. Most seizures last only a few minutes and many individuals receive enough of a warning to avoid falling or other injury. If an individual has a seizure:

* Keep calm. You cannot stop a seizure once it has started. Do not restrain the person.
* Clear the area of hard, sharp or hot objects which could injure the person. Place a pillow or a rolled-up coat under the person' s head.
* Keep crowds away.
* Do not force anything between the teeth.
* Loosen tight clothing but do not interfere with movements.
* Remember that the person does not breathe well and skin color may be affected.
* After the seizure, the person may be confused and should not be left alone.
* Medical help may be needed only if breathing stops, the person continues to have seizures one after another or becomes seriously injured.

"No" Words

Just as some well known, four letter words are offensive, so are some words used in referring to people with disabilities. Here are some to avoid when speaking to or about people with disabilities.

Afflicted - It is negative and suggests hopelessness.

Cases - Sounds like something to be filed away and institutionalized.

Cerebral palsied - Sounds like an inanimate object instead of a person. The correct discription is "person with cerebral palsy."

Confined to a wheelchair - A person uses a wheelchair.

Courageous - People with disabilities are not unusually brave and do not want to be regarded as super heroes. Like everyone else, they have the will to live and enjoy life's pleasures.

Crippled - This paints a mental picture of a person who can't do anything, someone whom people would rather ignore.

Deaf and dumb or deaf mute - These out-of-date terms were used to describe a person with deafness who also could not speak. Many individuals with deafness or hearing impairments can speak, although their speech may be hard to understand. Deafness does not make a person dumb or ignorant.

Disease - Describes a contagious condition. Most people with disabilities are as healthy as anyone else.

Epileptic - Individuals with this condition prefer to be referred to as persons with epilepsy.

Gimp - This out-of-date word was once used to describe someone who walked with a limp. It is a putdown.

Normal - Refers to numbers, not people. When used to describe a non-disabled person, it suggests that a person with a disability is abnormal or subnormal.

Patient - Hospitals and doctors have patients. Most people with disabilities are not in hospitals or regularly cared for by doctors. Rather they are self-relient members of the community.

Poor - Describes a person who lacks money or one to be pitied.

Retard, retardate or retarded - Because some people with disabilities are at times considered awkward, this does not mean that they are retarded. Individuals with mental retardation prefer to be called by their own names.

Spastic - Some people with disabilities lack coordination but this is only a product of the physical disability and should not be ridiculed.

Suffering - To say that someone suffers from a disability means that he or she is in constant pain as a result of the disability. This is rarely the case.

Unfortunate - This implies unlucky, unsuccessful or social outcast. Whether or not luck had anything to do with a person becoming disabled, he or she wants to be regarded as a real, likable person.

Victim - Victims are people sacrificed by an uncontrollable force or agent. People with disabilities do not want to be considered as helpless victims but as people - with many worthwhile attributes.

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WHO ARE THE HANDICAPPED: A CLARIFICATION OF TERMS

The terms impaired, disabled, and handicapped are often used synonymously and interchangeably. Society imposes labels, particularly upon individuals with various physical, mental, emotional, and social conditions. There are important differences among the terms impaired, disabled, and handicapped, and different degrees of affliction. These terms are differentiated in the way individuals with various conditions look upon themselves, not in ways that have been culturally imposed by society and by persons without any of these conditions.

- Impaired individuals have identifiable organic or functional conditions; some part of the body is actually missing, a portion of an anatomical structure is gone, or one or more parts of the body do not function properly or adequately. The condition may be permanent, as in the case of amputation, congenital birth defect, cerebral palsy, brain damage, or rectolinial fibroplasia. It may be temporary--functional speech defects, some learning disabilities, various emotional problems, certain social maladjustments, or specific movement deficiencies.
- Disabled individuals, because of impairments, are limited or restricted in executing some skills, doing specific jobs or tasks, or performing certain activities. Individuals with certain impairments should not be automatically excluded from activities because the condition makes it appear that they cannot participate safely, successfully, or with satisfaction. Some impaired persons attain high levels of excellence in activities in which they are not supposed to be able to perform or participate.
- Handicapped individuals, because of impairment or disability, are adversely affected psychologically, emotionally, or socially. Handicapped persons reflect an attitude of self-pity. Some individuals with impairments and disabilities are handicapped, some severely. Others with severe impairments or disabilities adjust extremely well to their conditions and live happy and productive lives. In their eyes they are not handicapped even though society continues to label them handicapped. Undoubtedly many persons in society with neither an impairment nor a disability are handicapped!

Source: Making Workshops Work in Physical Education and Recreation for Special Populations, AAHPERD, 1900 Association Drive, Reston, VA 20043, March 1976.

Since many persons may only rarely come into contact with a handicapped individual, their reactions may be based upon stereotypes or misconceptions about a particular condition. Because people often tend to fear or avoid contact with what they do not understand, it is important that clear, factual information concerning handicaps be given. That is the purpose of this unit.

While discussing the characteristics of some of the more common handicaps, please remember that a handicap cannot be understood or regarded simply as a medical problem. It is also a social concern. The handicapped person does not exist in a vacuum. Society greatly affects the self-concept of the handicapped individual and the attitudes and responses of individuals around him. As a member of society, you can learn to "THINK OF THE ABILITIES RATHER THAN THE DISABILITIES."

People have devoted years of study and experience to understanding and treating individuals with handicaps. The results cannot all be included in one unit; but a summary of the characteristics of handicapping conditions gives background for reaching out to handicapped persons. And remember--do not be afraid to ask questions--of parents, teachers, medical professionals, recreation professionals, social workers, and especially, of the handicapped person, who may be the best source of information on what he/she is or is not able to do.

There are many handicapping conditions but those most often found in people are included in this chapter. Many characteristics of these handicaps do overlap. Also, some individuals may have more than one handicap. Consider these thoughts as you use this section. Following is a list of the contents to assist you. Let's look at. . .

Physical Handicaps

- Visually Impaired
- Hearing Impaired
- Hearing and Visually Impaired
- Amputation
- Spinal Cord Injuries

Crippling and Neurological Disabilities

- Cerebral Palsy
- Muscular Dystrophy
- Spina Bifida

Mental Handicaps

Mental Retardation

Emotional Disabilities

Behavior Problems

VISUALLY IMPAIRED

Vision ranges from severely limited to totally absent. The definition used for legal purposes, 20/200 vision or less in the better eye after correction, indicates that the person sees at 20 feet what a sighted person sees at 200 feet. Partially sighted people have vision between 20/70 and 20/200. Although some people perceive only large objects or shadows, some function very well using corrective lenses.

For the individual who is meeting a visually impaired person for the first time, there are a few simple guidelines to follow, based primarily upon common sense and the same basic sensitivity and politeness shown towards any individual.

When meeting a visually impaired person, begin by introducing yourself and making sure that he is aware that you are talking to him. Likewise, when you leave, tell him that you are going. Never make visually impaired people guess who you are or wonder whether you are still there. Speak directly to him in a normal tone of voice. If he is with friends, do not use a third person as an interpreter. Do not shout at someone who is visually impaired as if they were hearing impaired. When talking to a visually impaired person use the words you normally use: do not try to avoid words like "look" and "see" that are part of everyone's vocabulary, including the visually impaired person's.

When offering to act as a guide, ask the person to take your arm, just above the elbow, and walk about half a step ahead of the person. Never grab the person's cane and do not insist upon helping someone who does not want assistance. When a guide dog is being used for travel, do not distract the dog from his job by petting or talking to him.

When interacting with a visually impaired person, think of him in the same way you would think of any other person. Remember he is just like other people except he depends upon hearing, touching, tasting, and smelling instead

of seeing. He needs all the experiences any person would have, but because he cannot see, he will need a lot of encouragement to experiment with new things. Of course, you must help him avoid some dangerous places and things, but try not to overprotect him.

When you are with a visually impaired person, make an effort to describe things, and let him touch, taste, or smell if possible. Let him touch you--your face, your clothes, your watch, etc. Talk about the things he explores. When you visit a different place, guide him around, explaining what you see and letting him feel key items.

Visually handicapped people may use certain devices to help them. They read and write using a touch system of raised dots called Braille. Recordings of books and magazines ("Talking Books") are also available. Partially sighted people may be able to read using a magnifying glass or enlarged print.

HEARING IMPAIRED

True deafness is defined as a hearing loss in both ears severe enough to prevent communication through the ear, even with amplification. Hearing losses can vary from mild, when the person has difficulty hearing faint or distant speech, to severe, when the person only feels vibrations. Some people have a combination of types of hearing losses. Many people with deafness due to nerve or brain damage may have associated handicaps.

The hearing impaired person is usually eager to communicate and knows his own best ways to succeed at it. Regardless of the communication method used, remember to establish and keep eye contact throughout the conversation. You, as the hearing partner, should accept the choice of the deaf person.

Oral Speech

> Speech is easy for you and most difficult for the hearing impaired person. This story of three hearing impaired ladies on a shopping trip shows some difficulties encountered when conversing by speaking and lip reading. The first lady says to the others, "Windy today, isn't it?" The second says, "No, it's Thursday." The third says, "I'm thirsty too. Let's go and have a drink." As you can see, the person choosing speech and lip reading faces a real challenge. Lots of encouragement is needed. When talking with a hearing impaired person, face the light, so that your mouth can be seen, and speak slowly and clearly. Do not exaggerate or raise your voice. Try to be expressive; facial expressions are an important clue to what you are trying to convey. When explaining

directions, a demonstration may be more helpful than a verbal explanation. Keep your language at the person's level. Accept repetitions until the person gives up, but never pretend to understand if you do not.

Finger Spelling

Finger spelling is a good choice for people with inadequate speech, since the majority of them have mastered this skill. It consists of spelling the letters of each word in the air and is easy to learn, the only difficult part being to read it back from the partner. Keep in practice, and ask the person to go slowly at first.

Sign Language

Signing involves the combining of larger units of utterance into manual symbols. Taking a course in signing or having an interpreter available will assist communication between deaf and hearing persons.

Simultaneous Means

Combinations of the possibilities previously mentioned make communication possible.

Writing

This should be the last resort.

If the person wears a hearing aid, be sure he has it on at all times, except swimming. Hearing aids have various settings; ask the person to show you how to adjust it. Not all people who wear hearing aids can understand speech with the aid. Many still rely on other forms of communication. In any case, always speak clearly and directly without raising your voice.

Except for activities which involve hearing and speaking, there is little difference in the way you should treat hearing-impaired people from the way you would treat any other person. Like any person, hearing-impaired people need opportunities to be independent and self-confident in their own abilities.

HEARING - VISUALLY IMPAIRED

The combination of hearing and visual impairment results in a severe handicap. Some people may still have some residual vision or hearing. The hearing-visually impaired person who has lost all his vision or hearing has only his senses of touch, taste, and smell. With only these senses to learn about his world, he needs a great deal of guidance. He needs opportunities to "see" things through touching, tasting, and smelling. Give him opportunities to feel what you are doing--taking off your coat, eating with a spoon, washing the dishes, sweeping, watering the flowers. When he is ready, you can show him how to do these things by helping him imitate your motions. A hearing-visually impaired person may even need to learn how to play.

Even though the hearing-visually impaired person you are caring for cannot hear you, continue to speak to him just as you would to any other

person. You will find yourself more relaxed and able to relate to him. Let him feel your mouth or throat if he seems interested.

Remember that the hearing-visually impaired person may take longer to learn to do things than the non-handicapped person. Although this condition is often associated with mental retardation, it does not necessarily mean there is any intellectual deficit. He will always need time and patience in learning a new skill. All people need the security of being loved. Since the hearing-visually impaired person cannot see a smile or hear your praise, you must make an effort to show affection physically. A kiss or a hug not only conveys affection, but also promotes self-confidence.

AMPUTATION

An amputee has experienced the partial or total loss of one or more limbs. Amputations exist, or are performed, for a wide variety of reasons. The adjustment is often easier for a person born without a limb, and may be more difficult when the amputation occurs when the person is several years old and accustomed to use of the limb. Some terms used to identify amputations are:

Unilateral - one arm or one leg
Bilateral - two arms or two legs
Double - one arm and one leg
Multiple - more than two extremities
Above Elbow(A/E) Below Elbow(B/E)
Above Knee(A/K) Below Knee(B/K)

In most cases an artificial device, a prosthesis, is fitted to the stump(s) to replace the missing limb(s). The amputee will have clear instructions relating to the care of the stump, which is crucial. Exercise, massage, and conditioning of the unamputated limbs is essential. Also, special care is in order at the earliest possible moment if skin troubles develop. If abrasions occur, they should be washed gently, covered with antiseptic and sterile gauze, and the prosthesis should be given special attention to assure that it is clean and dry. Small blisters may be treated in this manner but large blisters should have immediate medical attention.

During the period of relearning and adjustment, the amputee may require support and encouragement not only from those who are directly involved in his training, but also from his family, peers, and counselor. Effective training will give attention to the physical activities and psychological needs of the amputee. There is no amputee personality as such. The reaction

of the amputee to his loss can be predicted to some degree on the basis of how he has reacted to stress in the past.

Although there are wide variations in the manner in which amputees are able to accept their loss and make satisfactory and satisfying adjustments, amputees in general may be helped to--

- develop new and attainable goals in the various areas of living--personal, social, educational, and vocational.
- form plans for reaching these goals.
- include their changed bodies in a relatively satisfying self-concept.
- seek out and use a wide range of personal and community resources in the realization of hopes and expectations.

Functional limitations which should be considered for upper extremity amputees are:

climbing	throwing
crawling	pushing
reaching	handling
lifting	pulling
carrying	fingering
foot-eye-hand coordination	

Functional limitations which should be considered for lower extremity amputees are:

walking	twisting	lifting
jumping	standing	carrying
running	turning	
balancing	stooping	
climbing	crouching	
crawling	kneeling	

SPINAL CORD INJURIES

Spinal cord damage is usually a consequence of some type of trauma to the spine although it may also be caused by disease. This can result in both motor and sensory impairments. The degree of impairment is determined by the level at which the trauma occurred and the severity of the damage to the spinal cord. The two major resulting impairments of the spinal cord are termed paraplegia or quadriplegia. As in other impairments, the degree to which a

person has adjusted to his specific impairment will determine the extent of mobility achieved. Therefore, people with the same level of spinal damage and severity will be able to do many different activities with differing degrees of success.

Paraplegia

Paraplegia refers to partial impairment or paralysis and consequent loss of the use of both legs and lower part of the body. This occurs as a result of damage to the spinal cord at the thoracic or lumbar level. In addition to traumatic paraplegia, impairment may also result from cerebral palsy, muscular dystrophy, and multiple sclerosis.

Because of the length of the spine involved in paraplegia, there will be a vast difference in the degre of mobility found in individudals that are considered to be paraplegic. Generally, the lower the spinal cord damage occurs, the greater the upper body strength, lateral stability, and functional mobility there will be. In more severe cases, there is still full function of the arms, neck, shoulders and hands.

Depending upon the level of damage, the paraplegic will need the use of (or combinations of) assistive mobility devices such as a wheelchair, crutches, and/or braces. The paraplegic should be encouraged to use a wheelchair (if needed) as a functional machine in which to travel and not as an embarrassing reminder of an impairment. The desire is to achieve the highest degree of mobility possible and the wheelchair is an effective device toward this end.

When developing activities involving paraplegics you should keep several things in mind. The person should be encouraged to use as much of the remaining function in the body as he can. Twisting, turning, reaching, pushing, pulling and throwing type activities are important for keeping the upper body in shape. Cardiovascular needs are also important to overall fitness. Swimming is an excellent activity for these considerations. It is also extremely important to prevent excessive weight gain which can easily happen as a result of inactivity. Practicing good nutrition and maintaining a regular exercise program will help achieve this aim and allow the paraplegic to pursue an active life in all areas.

Quadriplegia

Quadriplegia occurs when there is impairment or paralysis involving all four extremities and the trunk. This is a result of damage to the spinal cord at the cervical level, which is basically the neck area. This damage usually will occur near the base of the neck because that is the area of the greater amount of neck movement and it is, therefore, more susceptible to injury because of this.

Quadriplegics will nearly always require some attendant care; the amount depending on the actual level and extent of trauma and also the adjustment of the person to the resulting impairment. In any case, the upper extremities and neck are never totally paralyzed and some function, however small, can be expected. Some very high level paraplegics may also show similar characteristics as quadriplegics, but without sedentary activity deficiencies, and may make planning easier if included with quadriplegics.

When considering activities for quadriplegics, it is again important to encourage and stress using whatever bodily functioning remains. Ambulation is a severe problem. Varying degrees of wheelchair locomotion can be achieved and should be developed in order to decrease the amount of attendant care necessary in the house. Whatever neck, shoulder, hand, and arm movements that are possible should be stressed and exercises developed accordingly to keep these areas functioning. Quadriplegics may have respiratory problems so this should be considered when developing activities. Pressure sores (bed sores) are also a potential problem due to a loss of sensation at the level of spinal cord injury. Finally, a regular diet and plenty of fluid intake are extremely important to quadriplegics.

CEREBRAL PALSY

Cerebral palsy is a condition resulting from injury to the brain. "Cerebral" refers to the brain and "palsy" to lack of control over the muscles. In cerebral palsy, the muscles are not paralyzed, but uncoordinated.

There are many different types of cerebral palsy, and in many cases there will be a combination of two or more types. Common types of CP are:

Spastic - Characterized by tense contracted muscles with inability to move smoothly. A person may be spastic only in his legs, on one side of his body (arm and leg) or in all four limbs.

Athetoid - Characterized by constant uncontrolled motion, even at rest. Athetoid movements intensify with excitement.

Ataxic - Damage in the area of the brain concerned with balance which leads to many falls.

Tremor - Constant shaking, especially in the arms and hands, limits abilities.

Because the brain controls all bodily functions, damage to brain cells can result in impairments in other areas besides muscle function. In addition to lack of motor control, there may be seizures, spasms, mental retardation, abnormal sensation and perception, or impairment of sight, hearing, or speech, all in varying degrees.

Because of the complex nature of cerebral palsy, you will have to rely on the teacher or parent to teach you the best way to handle the child. A CP person may use specialized equipment. If he wears braces, be sure to watch how they are put on and removed. If he uses a wheelchair, know how to position the person properly in the chair, how to operate the brakes, how to maneuver up and down curbs, and how to open or fold the chair. Different people will require different adaptations on their wheelchairs. Some people with cerebral palsy walk with crutches, some wear corsets to help them sit upright, and some wear braces or casts at night to prevent deformities. The teacher or parent should explain how to use these devices.

MUSCULAR DYSTROPHY

The term muscular dystrophy refers to a group of diseases which are characterized by weakness and wasting of the voluntary muscles (those over which there is conscious control of the body). The most common, and most serious type of MD (Duchenne's) usually affects young boys between the ages of 2 and 6. Fat replaces the muscle fibers and weakness progresses rapidly. Deformities may develop and a child with this type of dystrophy is usually confined to a wheelchair in early teens. In the last stages of MD, when the muscles are completely wasted, the child is often extremely thin. Children with this form of MD rarely live past 20 as they are unable to cope with respiratory infections.

Exercise is vitally important for the child with MD. By keeping the remaining muscles as functional as possible, avoiding or slowing down the development of complications that come from the progressive loss of muscle activity is possible. When you are caring for a child with MD, be aware

of his/her capabilities. Take care not to overtire the child. Do not allow the child to become chilled following swimming or strenuous activity. A slight cold can result in hospitalization for a child with MD.

Because the dystrophic child is less mobile than the non-handicapped child, gaining weight is a common occurence. Some children will eat as a substitute for the many things they cannot do. Many MD children have diet restrictions that you should be aware of, as an increase in fat intake can speed up the weakening process.

The child with MD may use various devices including braces, crutches, corsets, wheelchair, or specialized aids for feeding or dressing. A special toilet seat may be necessary; however, MD children usually retain bowel and bladder control. Encourage the child to use equipment, as it will enable him to be more active and self-sufficient.

In advanced states of MD, the bones become very fragile. You must take great care in handling such children as they are prone to fractures. It is important to realize in lifting a child with MD, the muscles are like jelly and you cannot get a good hold on the child. Special lifting devices may be necessary. A teacher or parent should explain to you what assistance the child may need in getting from one place to another.

You will find that many MD children are afraid to try new things. They become discouraged as they watch their bodies weaken with no hope for recovery. You can help these children by encouraging them to develop hobbies using remaining abilities. The small muscles of the hands are often the last to be affected by MD. Even severely weakened children can often enjoy drawing, finger painting, or simple board games. Muscular dystrophy does not lead to mental retardation. Severely affected children often spend a great deal of time reading.

SPINA BIFIDA

Spina bifida is a birth defect in which part of the backbone that covers the spinal cord fails to develop, leaving the spinal cord exposed in one spot. There are five major types of spina bifida. Many children with spina bifida have no symptoms and require no treatment. Some babies are born with a thin walled sack called a meningocele protruding from their back. When this sack contains a part of the defective spinal cord which has slipped through the abnormal opening in the spine, it is called myelomeningocele. The cause of this malformation, which occurs during the

end of the first month of pregnancy, is unknown.

The child with myelomeningocele is likely to have a number of problems: paralysis of lower limbs, loss of sensation, lack of bowel and bladder control, deformities, susceptibility to infection, and/or hydrocephalus.

When caring for a boy or girl with spina bifida, there are several factors to consider. In each case, check with a teacher or parent about the correct procedures for each child. Eating, communicating, urinating, and mobility may be special concerns for the spina bifida child.

In many children, lack of coordination of the muscles of the face may result in uncontrolled grimacing, especially when attempting to speak. Tightness and poor coordination of the muscles of the jaw, mouth, and tongue lead to swallowing problems. The child may drool excessively, especially when concentrating on a task requiring effort. Tongue thrust, reverse swallow, and bite reflex are all problems which make eating difficult. In addition, many children do not have enough coordination to hold a spoon and bring it to their mouth or to drink from a cup, so adaptations must be made. A good sitting posture is vital; be sure to find out what supports are necessary. Know what problems you may encounter. Know how to assist the child, allowing as much independence as possible. Find out if there are any restrictions of the child's diet.

Urination can be managed in several ways. Some children wear urine collecting devices. Other children may learn to empty the bladder at regular intervals and press the abdomen to expel as much urine as possible from the bladder. Regular toileting is very important as urinary infections are common, due to fluid remaining in the bladder.

With extensive bracing, some children are able to stand daily at a specially designed standing table. Using braces and a walker or crutches, some children are able to walk. Many use wheelchairs.

When you are caring for a child with myelomeningocele, you must rely on the teacher or parent to show you how to use the equipment that the child requires. Because many of these children are not using their legs as non-handicapped children do, their leg bones are extremely fragile and apt to break. Take care in moving the child with floppy legs, especially when the braces are off. Never try to get the child to stand without the brace

At all times, remember to concentrate on what the child <u>can do</u>, and give assistance only when needed. When you do things for him that he can

do himself, you actually handicap the child more. If you are patient and supportive, you can be an important factor in helping the child overcome the disability. With all this in mind, try to remember that although myelomeningocele is a complex disability requiring numerous different types of specialized care, the child needs attention other than just medical care. Encourage the child to use his abilities and develop confidence in himself. All children need to feel good about their accomplishments.

MENTAL RETARDATION

Mentally retarded persons are those who develop at a below average rate and experience unusual difficulty in learning, social adjustment, and economic productivity. Mental retardation should not be confused with mental illness or emotional disturbance, although a retarded person may--like anyone else--become emotionally disturbed. Mentally retarded people simply have a learning problem; they learn slower than others.

Just as there are different levels within the range of normal intelligence, there are different levels of mental retardation. The levels and general characteristics of each level are:

Mild	Mental Age	8-9 yrs.	IQ 50-69
Moderate	Mental Age	5-7 yrs.	IQ 40-49
Severe	Mental Age	3-4 yrs.	IQ 20-39
Profound	Mental Age	0-2 yrs.	IQ 0-19

General Characteristics

Mildly Retarded

Can take care of self and they are educable
1) Often appears normal to casual observer.
2) May achieve academic skills to fourth grade level.
3) Can benefit from vocational training.
4) Can be self-supporting, unskilled employee.

Moderately Retarded

Slow, trainable under sheltered conditions
1) Generally progresses from kindergarten to first grade.
2) Tends to be self-sufficient under supervision.
3) May become self-supporting in service occupation.

Severely Retarded

Custodial--need constant supervision
1) Can usually learn to talk, though limited.
2) Can be trained in most basic self-help skills.
3) Can do simple tasks under supervision.
4) May become partially self-supporting in a sheltered environment.

Profoundly Retarded

Custodial--need constant supervision
1) Less intellectual ability than the average three-year old.
2) Might develop regular toilet habits.
3) Might be trained to feed and dress self.
4) Often cannot talk or communicate.
5) Requires continued care through life.

A slightly different classification system is used in the education system. Educators refer to Educably Mentally Handicapped (EMH) children and Trainable Mentally Handicapped (TMH) children. EMH roughly approximates the Mild and Moderate IQ range while the TMH categorization for educational purposes is more similar to the Severe and Profound range.

A mentally retarded person often acts younger than he or she actually is. In more severely retarded people, the gap between abilities and age is even greater. When you are with a mentally retarded person, keep in mind his abilities, not his age; although be careful not to provide/offer extreme age inappropriate activities.

Mentally retarded people do not necessarily need special equipment and treatment in order to play and learn. They need varied experiences just like any other person. Every person learns about himself and his environment by feeling, seeing, hearing, and moving about. The mentally retarded person learns the same way, but slower.

It is important to structure the activities of the mentally retarded person. He is apt to have a very short attention span so that he is unable to concentrate on one activity for more than a few minutes. He needs numerous activities, active and quiet, easy and challenging, but always suggested with his abilities in mind. Directions may need to be repeated or broken down into simple steps or basic concepts. Give him plenty of time to complete a task. His reactions may be very slow and he may become frustrated easily. Be sure to praise all his efforts, however small.

Mentally retarded people may need firm and consistent limits. However, one must remember that the mentally retarded person's abilities and level of comprehension are lower than would be expected for his age, so expectations for his behavior must be adjusted accordingly. This doesn't mean that mentally retarded people are never naughty. They need a lot of praise and affection, but they also need discipline. Be caring but firm.

As with any handicapped person, the parents or guardian of a mentally retarded person will probably be your best source of information. Mentally

retarded people are apt to be less flexible than other people, so become familiar with the person's daily routine as well as any special equipment or medication he may require. Prepare him ahead of time for any changes or new experiences.

BEHAVIOR PROBLEMS

There are many times when children display behaviors which are not socially acceptable. Temper tantrums, excessive crying, screaming or holding the breath are a few examples. Unacceptable behavior may be the result of fears, frustrations, or the failure to satisfy the child's basic needs for love and security. As the child develops, how he learns to deal with his fears, frustrations, and unmet needs is very important to the child and his personality. If a child feels so much stress and anxiety that it interferes with normal daily functioning, he is likely to express his anxieties through inappropriate behavior. Then it can be said that the child has a behavior problem. Given this definition, all children at times have behavior problems, some for only a week, or a month, but others continuously throughout their lives. Children who have repeated behavior problems may require professional assistance. Each child is unique; within limits, what is inappropriate and unacceptable behavior for one might be acceptable behavior for another.

There are various techniques for dealing with behavior problems, most of which stress structure and consistency. It is very important to recognize who the child is and then to provide him with the assistance and support necessary for the development of his potential.

MEETING COMMUNICATION NEEDS OF INDIVIDUALS WITH HANDICAPPING CONDITIONS

Before you can be of much help to the disabled person in communication, or in any other dimension, you must have developed a healthy attitude toward that person and to the role you can play with him. It involves, among other things, a sincere acceptance of him as a person, and an equally sincere attitude on your part of rendering service without "do-gooder" overtones.

Each person will have a channel or channels of communication which work best. Channels may be verbal, auditory, gesture, or written. Your responsibility will be to learn to communicate with individuals through their most effective channel. The process will require time and effort on your part, but you will be amply rewarded. It will open the door to any other approach you wish to make -- in recreation, in socialization, in stimulating new knowledge.

Because each person will have individual problems and characteristics, we can only make general suggestions which can then be adapted to specific instances. However, considering the many things which can affect the normal development of speech, there are several points which are important to think about when you work with a particular person. For example, you may find that you can be much more easily understood if you speak more slowly and simply. Rapid speech may simply confuse and discourage individuals with handicapping conditions. Also, communication should be easygoing and relaxed. Further, you may find it desirable to ask questions so that responses can be simple and yet definite. A "yes" or "no" or even a simple nod can convey much meaning if preceded by an appropriate question. In any event, give ample time for the person to respond. Communication should involve the use of a fairly limited vocabulary, simple sentence structure, and also the introduction of items of information which most of us take for granted. Repetition and reinforcement will hasten the learning experience. In summary, remember to:

- Have a healthy attitude.
- Learn individual channels of communication.
- Establish a reason for communication.
- Structure the situation for successful communication.
- Work at their language level.
- Be patient.

Source: Adapted from 4-H Leader's Guide:
"Lets Look at 4-H and Handicapped Youth"
Cooperative Extension Service
The Pennsylvania State University
University Park, PA 16802

TYPES OF PHYSICAL LIMITATIONS

The following describes six major types of physical limitations or involvement, which refers to a portion or portions of the human anatomy and or physiology that have a loss or impairment of normal function as a result of genesis, trauma, disease, inflammation, or degeneration. The six basic categories of involvement in this report are:

(1) Non-ambulatory disabilities are those impairments that, regardless of cause, confine individuals to wheelchairs;

(2) Semi-ambulatory disabilities are those impairments that cause individuals to walk with difficulty or insecurity; examples include individuals with cardiac and pulmonary ills, those who require the use of braces, crutches, or canes, as well as persons who are arthritics, amputees, or spastics;

(3) Incoordination disabilities include faulty coordination or palsy due to brain, spinal, or peripheral nerve injuries;

(4) Aging disabilities are those manifestations of the aging process that significantly reduce mobility, flexibility, coordination, and/or perceptiveness;

(5) Sight disabilities range from total blindness to impairments affecting sight so that the individual functioning in public areas is insecure or exposed to danger;

(6) Hearing disabilities include deafness or hearing problems which might make an individual insecure in public areas because he/she is unable to communicate or hear warning signals.[1]

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[1]National Society for Crippled Children and Adults, American Standards Association Specifications for Making Buildings and Facilities Accessible to, and Usable by the Physically Handicapped, Chicago National Society for Crippled Children and Adults, 1961 (reaffirmed 1971), page 6.

When considering the six basic types of involvement, it must be realized that all six groups will not need nor necessarily want the same standards to provide increased usability. However, it can be assumed that if the design meets the requirements of the most severely disabled, it should also work for the less disabled as well as able bodied individuals.

Before getting into the actual criteria themselves, there are general principles and considerations relating to the non-ambulatory and semi-ambulatory categories which must be presented.

WHAT ARE LEARNING DISABILITIES?

Although individuals with learning disabilities usually have average to above average intelligence and the potential for achieving in a wide variety of areas of adult life, they may be characterized as lazy, irresponsible and unmotivated. Generally the term "learning disabilities" refers to a broad spectrum of processing disorders that arise from inaccurate information received through the senses, an inability to remember or integrate information, or difficulty with oral, written, and nonverbal expression. The description used by the Learning Disabilities Association of America (1986) is as follows:

> "Specific learnig disabilities is a chronic condition of presumed neurological origin which selectively interferes with the development, integration, and/or demonstration of verbal and/or nonverbal abilities. Specific learning disabilities exists as a distinct handicapping condition which varies in its manifestations and in degree of severity. Throughout life the condition can affect self-esteem, education, vocation, socialization, and/or daily living activities."

This description points out that learning disabilities are naturally part of of the individual and not a set of behaviors that have been acquired. It also points out that no specific area will be affected in every individual; in other words, each individual with learning disabilities has a unique set of learning difficulties and those difficulties will always be present. Individuals, however, can learn to cope with those difficulties. As indicated, learning disabilities affect all aspects of life and can cause problems with self-esteem, interpersonal relationships, and independent living skills. As mentioned earlier, a learning disability is indicated by problems in taking in, storing, retrieving or expressing information. As research and experience have shown, learning disabilities are not related to mental retardation in any way. Rather, learning disabillities reflect a discrepancy between an individual's ability and performance levels and the assumption is usually that the individual has at least average intelligence. The measurement of ability and performance, either in formal testing or in the instructional setting, can be particularly frustrating in that results will most likely be inconsistent. That is, in one area, the individual with a learning disability will demonstrate high to very high aptitude and achievement, while, in another area, results will indicate below average to very low performance.

GENERAL

1. People with handicapping conditions have the desire, determination, and ability to participate with everyone else. All they need is the chance to be included and that comes from you.
2. Treat the participant as a person, just like anyone else in your program.
3. Have a positive attitude toward the person. Let this be a model for other program participants.
4. You may need to spend extra time allowing the person to get things said or done.
5. Be sure to address the person directly, instead of through another member of the group.
6. Try to foresee and eliminate unexpected barriers or conditions that may result in problems.
7. Choose activity areas that allow all people to participate.
8. By providing a barrier-free environment you are encouraging participation by all members of the group.

SPECIFIC DISABILITIES

Physical Disabilities

Ask a disabled member what help is preferred. Assist only as needed. Be courteous, use common sense, and communicate concern.

Examples of Physical Handicaps:

Blind

- Speak in a normal voice using normal vocabulary words.
- Demonstrate by touch, taste, and smell.
- Describe the surrounding environment--location, shapes, and distances of objects.
- Remove/minimize all hazards in the area.
- Capitalize on all remaining sensory receptors in activities. Add a bell to the ball and play circle dodge ball. Run relays in roped-off lanes. Train for mobility through dance movements or rhythm bands.
- Contact an agency serving the blind. Many games have been adapted in braille and are commercially available.

Deaf

- Maintain eye contact. "V" or "U" shaped and semicircles are the best seating formations.
- Speak slowly and distinctly at the person's language level.
- Demonstrate explanations.
- Know about a hearing aid--its operation, care, and wearability.

Deaf-Blind

- Make your presence known by a simple touch that conveys friendly interest.
- Work out special communication signals between member and leader. Learn and use whatever communication method is known by the member. Be sure to understand each other.
- Encourage use of voice.
- Always orient the member to the surrounding environment.
- Let the member take your arm when walking.
- Swimming is enjoyed most in warm water.

Amputation

- Functional limitations depend upon amputee.
- Activities should exercise muscles surrounding affected body parts to avoid stiffness.
- Watch for falls as balance is a problem when body weight is not equally distributed.
- Encourage the individual to think of adapted methods.
- Contact a physical therapist or agency serving physically disabled persons. Special adaptive devices are available to help with some skills.

Crippling and Neurological Disabilities

Cerebral palsy

- Coordination is a problem. Motor activities such as running, jumping, or throwing are great. Fine motor activities using eye-hand coordination or delicate finger movements can be frustrating.
- Watch for falls--the sense of balance is not even.
- Avoid excessively loud sounds and sudden, unexpected movements. These increase uncontrollable spastic movements.

Muscular dystrophy

- Watch for signs of fatigue due to muscular weakness and respiratory difficulties.
- Watch for falls due to impaired sense of balance.
- Plan activities involving movement, as these exercise muscles. Activities such as climbing stairs which involve affected muscles require assistance.

. Participation in activities of all types is desired because youth eventually become wheelchair bound due to the nature of the disease.

. Once wheelchair bound, continue all activities manageable by the individual. Increase mental activities that use the imagination--the brain does not tire, only the muscles!

Spina bifida

. Know specifics about the extent of spinal cord injury and paralyzed body parts.

. Watch for signs of fatigue as endurance level is lower.

. Watch for falls since sense of balance is uneven.

. Specialized equipment often helps mobility and functioning--know specifics about use and care.

. Braces enable full participation but may slow movement.

. There is no sensation in injured areas. Watch for injury to the skin from burns (fire, too hot water) or scrapes. Watch for reddened areas resulting from pressure sores. Change sitting/lying position frequently. Watch for swelling and color changes due to circulation problems.

. Wheelchairs will be necessary for some.

Physical Handling Is An Important Consideration

Wheelchairs

. Be sure all straps are fastened securely. Sense of balance is not always good.

. Use arms and shoulder muscles when pushing wheelchaired participants up ramps.

. Guide a wheelchair down a ramp backwards.

. Use small foot bars to tilt wheelchairs backwards when going up/down low curbs.

. Change the position of the members in wheelchairs often to prevent sores and make them comfortable.

. Be sure brakes are positioned when member leaves the chair.

Crutches

. Ask what help is needed.

. Know how to hand crutches to a handicapped member.

. Hold at the waistline when assisting a person on crutches up an incline.

Braces

. Know when and how the braces are used.

. Know how to maintain the braces.

Falls

. Catch hold of the hips of a falling handicapped member to help regain lost balance.

. Try to break a fall to prevent much injury.

. Wait for a fallen handicapped member to indicate a need for help; allow a few minutes for rest.

. Check for serious injury and keep your eyes open.

Mental and Emotional Disabilities

Mental retardation

. Full participation in all recreational activities promotes interaction in an increasingly mature manner. Participants can do anything; their limits relate only to slower learning rates.

. Recognize that each individual has a chronological age, a mental age, an emotional age, a social age, and a certain degree of physical ability.

. Plan activities so that everyone has a chance to be good at something and to experience success.

. Be quick to praise.

. Break an activity into parts and present the most simple feat first.

. Alternate active and quiet games to avoid overstimulation and to compensat for short attention spans.

. Repeat well-liked activities.

. Include only one new activity in a meeting.

. Ease new members into the program gradually. . .have a youth advocate accompany the mentally handicapped youth to the first few meetings. The child feels relaxed and the leader gets first-hand information of the child's special needs.

. Be firm and take a positive leader role.

Behavior Problems

. Structure activities so that everyone participates in an organized manner.

. Vary the type of activity.

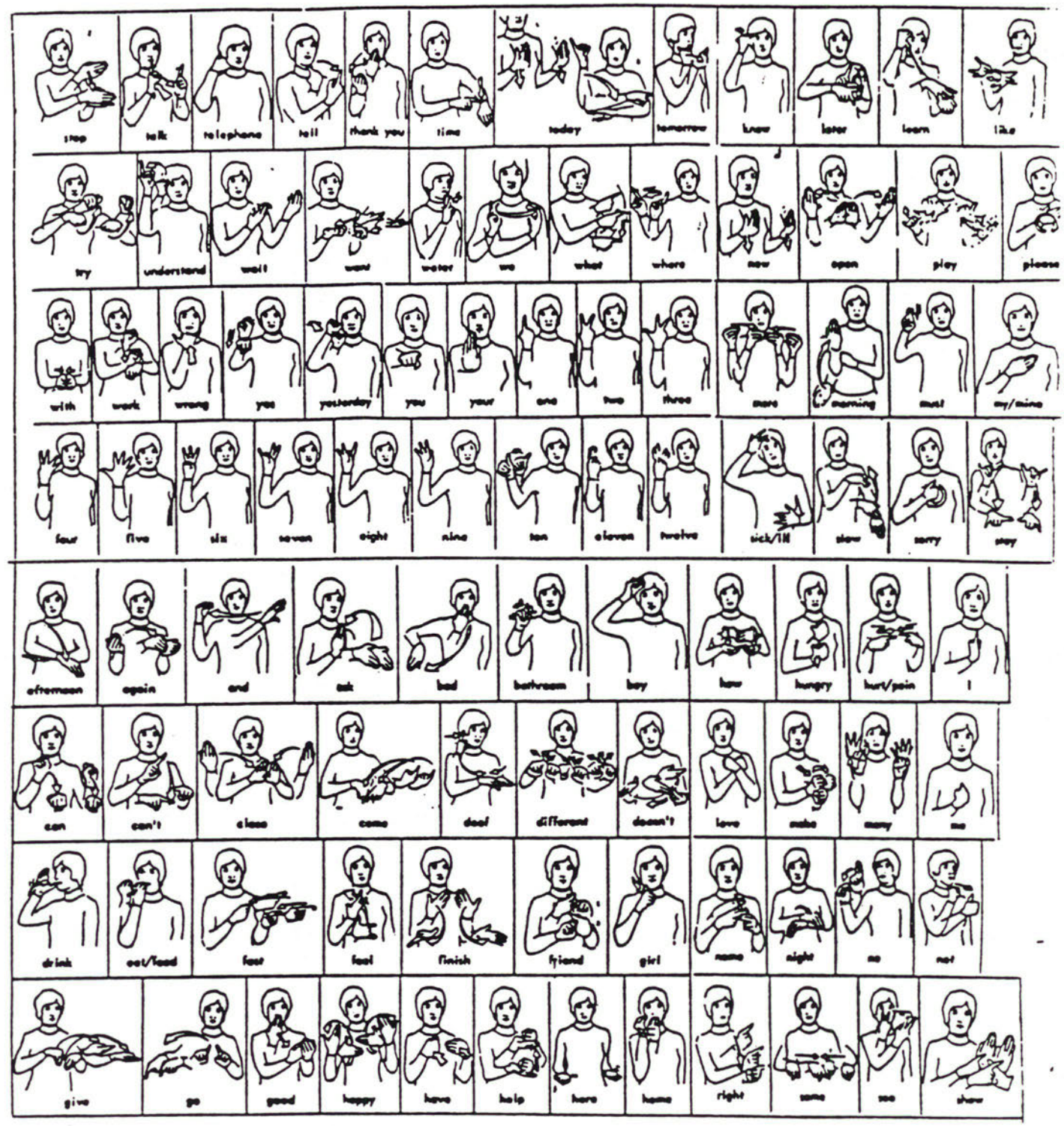
. Plan extra activities to fill a time slot completely.

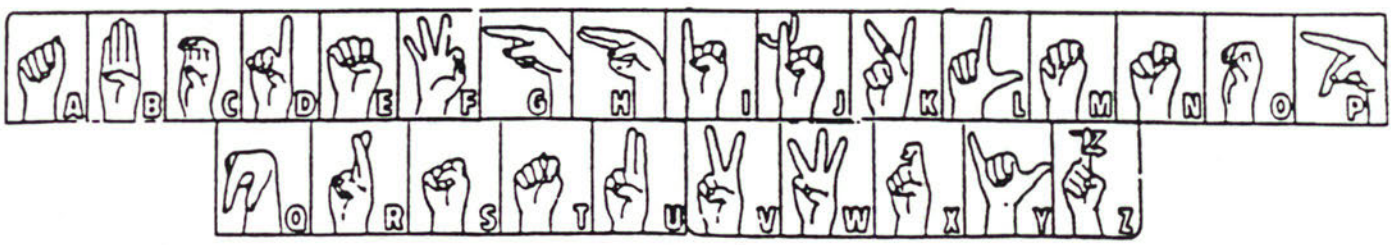
. Be consistent in what you say and do.

. Focus on the individual and support self-development.

Source: Project INSPIRE Resource Guide
David Austin, Lou Powell (eds.)
Department of Recreation and Park Administration
Indiana University
Bloomington, Indiana 47401

122 Work Survival Signs





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